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Operator's Signature — Date 12/21/03

2003 SENATE JUDICIARY

SB 2271

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2271

Senate Judiciary Committee

❑ Conference Committee

Hearing Date 02/11/03

Tape Number	Side A	Side B	Meter #
1	X		0.0 - 15.8

Committee Clerk Signature Mona L Solberg

Minutes: **Senator Stanley W. Lyson, Vice Chairman** , called the meeting to order. Roll call was taken and not all committee members present. Senator Stanley W. Lyson, Vice Chairman requested meeting starts with testimony on the bill:

Testimony Support of SB 2271

Arnold Thomas - President of the ND Health care Association (meter 1.2) Attachment #1. Discussed the history behind SB 2271 and handed out Hog House amendment. Discussed how this bill mirrors a MN legislative Bill

Amy Wald - Licensed Social Worker at Youthworks (meter 11.0) Read Testimony - Attachment #2.

Do to the complicated nature of the bill and the lack of Senators, Senator Stanley W. Lyson, Vice Chairman asked if any persons who would not be able to come back when we have quorum - Wednesday, February 12, at 11:00 they could testify now and the rest wait until that time. They did.

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2271

Senate Judiciary Committee

☐ Conference Committee

Hearing Date 02/12/03

Tape Number	Side A	Side B	Meter #
2	X		37 - End
3	X		0.0 - 8.1
Committee Clerk Signature	Moira L Solberg		

Minutes: **Senator Stanley W. Lyson, Vice Chairman,** called the meeting to order. Roll call was taken and all committee members present. Sen. Lyson requested meeting starts with testimony on the bill:

Testimony Support of SB 2271

Jonathan Byers - Assistant Attorney General (meter 40.4) Read paragraph form Marshal Law Review Article written by Julie Ditella. (meter 40.5) Read Testimony - Attachment #3. This bill does not criminally prosecute a mother for drug abuse, it only paves the way for entry into treatment. This would be the biggest step in prenatal care that an alcoholic mother could take.

Senator Thomas L. Trenbeath discussed another bill regarding deprived children (meter 44.3)

Senator Carolyn Nelson discussed "hog house" amendment.

Arnold Thomas - President of the ND Health Care Association (tape 3, side 1, meter 3.8) Voiced his support and introduced a letter from Dr. Ron Miller (following)

Dr. Ron Miller - Pediatrician and Medical Director of Children's Hospitals and Clinics at

MeritCare Health Systems in Fargo - Attachment #5

Testimony in opposition of SB 2271

None

Testimony Neutral to SB 2271

Karen Romig Larson - Director of the Division of Mental Health and Substance Abuse in the Department of Human Services. - (meter 48.3) Read Testimony - Attachment #4.

Larry Burnhart - County Social Services (meter 52.9) Discussed his concerns on what to do if a mother refuses help. If we receive a report and the mother refuses to participate in an assessment by law we have to leave her alone because we can not make a mental health commitment with so little information.

Senator Carolyn Nelson asked how many children are born with Fetal Alcohol Syndrome.

Discussion of the effects of alcohol Vs any other drug.

Discussion of statistics with Karen Romig Larson (tape 3, side 1, meter 1.9)

Motion Made to DO PASS Hog House Amendment to SB 2271 by Senator Carolyn Nelson and seconded by Senator Thomas L. Trenbeath.

Roll Call Vote: 5 Yes. 0 No. 1 Absent

Motion Passed

Discussion of Fiscal Note: Karen Romig Larson stated the impossibility to determine the impact.

This is a priority population already, but it would be under $50,000. It may be very little also?

But in the long run it will save the state immensely.

Motion Made to DO PASS SB 2271 with Hog House Amendments by Senator Thomas L.

Trenbeath and seconded by Senator Dennis Bercier.

Roll Call Vote: 5 Yes. 0 No. 1 Absent

Motion Passed

Floor Assignment Senator Carolyn Nelson

Senator Stanley W. Lyson, Vice Chairman closed the hearing

FISCAL NOTE

Requested by Legislative Council
02/18/2003

Amendment to: SB 2271

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$0	$0	$0	$0
Expenditures			$0	$0	$0	$0
Appropriations			$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The bill was introduced to enact new reporting requirements relating to child abuse and neglect assessments. The fiscal impact of this bill is undeterminable.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Debra A. McDermott	**Agency:**	Human Services
Phone Number:	328-3695	**Date Prepared:**	02/18/2003

FISCAL NOTE

Requested by Legislative Council
01/22/2003

Bill/Resolution No.: SB 2271

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The bill was introduced to enact new reporting requirements relating to child abuse and neglect assessments. The fiscal impact of this bill is undeterminable.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Debra A. McDermott	**Agency:**	Human Services
Phone Number:	328-3695	**Date Prepared:**	01/28/2003

38325.0101
Title.0200

Adopted by Senate Judiciary
February 12, 2003

2-13-03
1 of 4

PROPOSED AMENDMENTS TO SENATE BILL NO. 2271

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact three new sections to chapter 50-25.1 of the North Dakota Century Code, relating to prenatal testing and reporting; and to amend and reenact section 50-25.1-02 of the North Dakota Century Code, relating to child abuse and neglect reporting requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-25.1-02 of the North Dakota Century Code is amended and reenacted as follows:

50-25.1-02. Definitions.

1. "A person responsible for the child's welfare" means the child's parent, guardian, or foster parent; an employee of a public or private school or nonresidential child care facility; an employee of a public or private residential home, institution, or agency; or a person responsible for the child's welfare in a residential setting.

2. "Abuse of alcohol", "alcohol abuse", or "abused alcohol" means alcohol abuse or dependence as defined in the current diagnostic and statistical manual published by the American psychiatric association or a maladaptive use of alcohol with negative medical, sociological, occupational, or familial effects.

3. "Abused child" means an individual under the age of eighteen years who is suffering from serious physical harm or traumatic abuse caused by other than accidental means by a person responsible for the child's welfare, or who is suffering from or was subjected to any act involving that individual in violation of sections 12.1-20-01 through 12.1-20-08.

~~3.~~ 4. "Assessment" means a factfinding process designed to provide information that enables a determination to be made that services are required to provide for the protection and treatment of an abused or neglected child.

~~4.~~ 5. "Department" means the department of human services or its designee.

~~5.~~ 6. "Harm" means negative changes in a child's health which occur when a person responsible for the child's welfare:

a. Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or

b. Commits, allows to be committed, or conspires to commit, against the child, a sex offense as defined in chapter 12.1-20.

~~6.~~ 7. "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

2.14

~~7.~~ 8. "Local child protection team" means a multidisciplinary team consisting of the designee of the director of the regional human service center, together with such other representatives as that director might select for the team with the consent of the director of the county social service board. All team members, at the time of their selection and thereafter, must be staff members of the public or private agencies they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three members. The department shall coordinate the organization of local child protection teams on a county or multicounty basis.

~~8.~~ 9. "Neglected child" means a deprived child as defined in chapter 27-20.

~~9.~~ 10. "Prenatal exposure to a controlled substance" means use of a controlled substance as defined in chapter 19-03.1 by a pregnant woman for a nonmedical purpose during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery of the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

11. "Protective services" includes services performed after an assessment of a report of child abuse or neglect has been conducted, such as social assessment, service planning, implementation of service plans, treatment services, referral services, coordination with referral sources, progress assessment, monitoring service delivery, and direct services.

~~10.~~ 12. "State child protection team" means a multidisciplinary team consisting of the designee of the department and, where possible of a physician, a representative of a child-placing agency, a representative of the state department of health, a representative of the attorney general, a representative of the superintendent of public instruction, a representative of the department of corrections and rehabilitation, one or more representatives of the lay community, and, as an ad hoc member, the designee of the chief executive official of any institution named in a report of institutional abuse or neglect. All team members, at the time of their selection and thereafter, must be staff members of the public or private agency they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three persons.

SECTION 2. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to controlled substances - Reporting requirements.

1. An individual required to report under section 50-25.1-03 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that individual in that individual's official or professional capacity.

2. Any individual may make a voluntary report if the individual has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy.

3. If a report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under chapter 25-03.1.

4. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, an individual required to report under section 50-25.1-03 who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.

5. A report under this section must be made as described in section 50-25.1-04 and must be sufficient to identify the woman, the nature and extent of use, if known, and the name and address of the individual making the report.

SECTION 3. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Toxicology testing - Requirements.

1. If the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose, upon the consent of the pregnant woman, or without consent if a specimen is otherwise available, a physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance. If the test results are positive, the physician shall report the results under section 50-25.1-03.1. A negative test result or the pregnant woman's refusal to consent to a test does not eliminate the obligation to report under section 50-25.1-03 if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

2. If a physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy, the physician shall administer, without the consent of the child's parents or guardian, to the newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance. If the test results are positive, the physician shall report the results as neglect under section 50-25.1-03. A negative test result does not eliminate the obligation to report under section 50-25.1-03 if other medical evidence of prenatal exposure to a controlled substance is present.

3. A physician or any other medical personnel administering a toxicology test to determine the presence of a controlled substance in a pregnant woman, in a woman within eight hours after delivery, or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice. A physician or any other medical personnel who determines in good faith not to administer a toxicology test under this section is immune from liability for not administering the test.

4.14

SECTION 4. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to alcohol abuse - Reporting requirements.

1. An individual required to report under section 50-25.1-03 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol after the woman knows of the pregnancy may:

   a. Arrange for a chemical dependency assessment conducted by a licensed treatment program and confirm that the recommendations indicated by the assessment are followed; or

   b. Immediately report the circumstances to the department if the knowledge or suspicion is derived from information received by that individual in that individual's official or professional capacity.

2. An individual may make a voluntary report if the individual has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol during the pregnancy.

3. If the woman is referred for a chemical dependency assessment under subdivision a of subsection 1 and fails to obtain an assessment or refuses to comply with the recommendations of the assessment, an individual required to report under section 50-25.1-03 who has knowledge of the failure to obtain the assessment or refusal to comply with recommendations of the assessment shall make a report to the department.

4. If a report alleges a pregnant woman has abused alcohol, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment, if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under chapter 25-03.1.

5. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, an individual required to report under section 50-25.1-03 who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.

6. A report under this section must be made as described in section 50-25.1-04 and must be sufficient to identify the woman, the nature and extent of the abuse of alcohol, any health risk associated with the abuse of alcohol, and the name and address of the individual making the report."

Renumber accordingly

Date: February 12, 2003
Roll Call Vote #: 1

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2271

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number **38325.0200**

Action Taken Hog House Amendment

Motion Made By Sen. Nelson Seconded By Sen. Trenbeath

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	A	A	Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) FIVE (5) No ZERO (O)

Absent ONE

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: February 12, 2003
Roll Call Vote #: 2

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2271

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number **38325.0200**

Action Taken DO PASS with Hog House Amendment

Motion Made By Sen. Trenbeath Seconded By Sen. Bercier

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	A	A	Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) FIVE (5) No ZERO (O)

Absent ONE

Floor Assignment Senator Carolyn Nelson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 14, 2003 10:00 a.m.

Module No: SR-29-2705
Carrier: Nelson
Insert LC: 38325.0101 Title: .0200

REPORT OF STANDING COMMITTEE

SB 2271: Judiciary Committee (Sen. Traynor, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2271 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact three new sections to chapter 50-25.1 of the North Dakota Century Code, relating to prenatal testing and reporting; and to amend and reenact section 50-25.1-02 of the North Dakota Century Code, relating to child abuse and neglect reporting requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-25.1-02 of the North Dakota Century Code is amended and reenacted as follows:

50-25.1-02. Definitions.

1. "A person responsible for the child's welfare" means the child's parent, guardian, or foster parent; an employee of a public or private school or nonresidential child care facility; an employee of a public or private residential home, institution, or agency; or a person responsible for the child's welfare in a residential setting.

2. "Abuse of alcohol", "alcohol abuse", or "abused alcohol" means alcohol abuse or dependence as defined in the current diagnostic and statistical manual published by the American psychiatric association or a maladaptive use of alcohol with negative medical, sociological, occupational, or familial effects.

3. "Abused child" means an individual under the age of eighteen years who is suffering from serious physical harm or traumatic abuse caused by other than accidental means by a person responsible for the child's welfare, or who is suffering from or was subjected to any act involving that individual in violation of sections 12.1-20-01 through 12.1-20-08.

~~3.~~ 4. "Assessment" means a factfinding process designed to provide information that enables a determination to be made that services are required to provide for the protection and treatment of an abused or neglected child.

~~4.~~ 5. "Department" means the department of human services or its designee.

~~5.~~ 6. "Harm" means negative changes in a child's health which occur when a person responsible for the child's welfare:

a. Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or

b. Commits, allows to be committed, or conspires to commit, against the child, a sex offense as defined in chapter 12.1-20.

~~6.~~ 7. "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child care facility, a

treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

~~7.~~ 8. "Local child protection team" means a multidisciplinary team consisting of the designee of the director of the regional human service center, together with such other representatives as that director might select for the team with the consent of the director of the county social service board. All team members, at the time of their selection and thereafter, must be staff members of the public or private agencies they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three members. The department shall coordinate the organization of local child protection teams on a county or multicounty basis.

~~8.~~ 9. "Neglected child" means a deprived child as defined in chapter 27-20.

~~9.~~ 10. "Prenatal exposure to a controlled substance" means use of a controlled substance as defined in chapter 19-03.1 by a pregnant woman for a nonmedical purpose during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery of the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

11. "Protective services" includes services performed after an assessment of a report of child abuse or neglect has been conducted, such as social assessment, service planning, implementation of service plans, treatment services, referral services, coordination with referral sources, progress assessment, monitoring service delivery, and direct services.

~~10.~~ 12. "State child protection team" means a multidisciplinary team consisting of the designee of the department and, where possible of a physician, a representative of a child-placing agency, a representative of the state department of health, a representative of the attorney general, a representative of the superintendent of public instruction, a representative of the department of corrections and rehabilitation, one or more representatives of the lay community, and, as an ad hoc member, the designee of the chief executive official of any institution named in a report of institutional abuse or neglect. All team members, at the time of their selection and thereafter, must be staff members of the public or private agency they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three persons.

SECTION 2. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to controlled substances - Reporting requirements.

1. An individual required to report under section 50-25.1-03 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy shall report the circumstances to the department if the

knowledge or suspicion is derived from information received by that individual in that individual's official or professional capacity.

2. Any individual may make a voluntary report if the individual has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy.

3. If a report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under chapter 25-03.1.

4. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, an individual required to report under section 50-25.1-03 who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.

5. A report under this section must be made as described in section 50-25.1-04 and must be sufficient to identify the woman, the nature and extent of use, if known, and the name and address of the individual making the report.

SECTION 3. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Toxicology testing - Requirements.

1. If the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose, upon the consent of the pregnant woman, or without consent if a specimen is otherwise available, a physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance. If the test results are positive, the physician shall report the results under section 50-25.1-03.1. A negative test result or the pregnant woman's refusal to consent to a test does not eliminate the obligation to report under section 50-25.1-03 if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

2. If a physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy, the physician shall administer, without the consent of the child's parents or guardian, to the newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance. If the test results are positive, the physician shall report the results as neglect under section 50-25.1-03. A negative test result does not eliminate the obligation to report under section 50-25.1-03 if other medical evidence of prenatal exposure to a controlled substance is present.

3. A physician or any other medical personnel administering a toxicology test to determine the presence of a controlled substance in a pregnant woman, in a woman within eight hours after delivery, or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice. A physician or any other medical personnel who determines in good faith not to administer a toxicology test under this section is immune from liability for not administering the test.

SECTION 4. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to alcohol abuse - Reporting requirements.

1. An individual required to report under section 50-25.1-03 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol after the woman knows of the pregnancy may:

   a. Arrange for a chemical dependency assessment conducted by a licensed treatment program and confirm that the recommendations indicated by the assessment are followed; or

   b. Immediately report the circumstances to the department if the knowledge or suspicion is derived from information received by that individual in that individual's official or professional capacity.

2. An individual may make a voluntary report if the individual has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol during the pregnancy.

3. If the woman is referred for a chemical dependency assessment under subdivision a of subsection 1 and fails to obtain an assessment or refuses to comply with the recommendations of the assessment, an individual required to report under section 50-25.1-03 who has knowledge of the failure to obtain the assessment or refusal to comply with recommendations of the assessment shall make a report to the department.

4. If a report alleges a pregnant woman has abused alcohol, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment, if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under chapter 25-03.1.

5. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, an individual required to report under section 50-25.1-03 who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.

6. A report under this section must be made as described in section 50-25.1-04 and must be sufficient to identify the woman, the nature and extent of the abuse of alcohol, any health risk associated with the abuse of alcohol, and the name and address of the individual making the report."

Renumber accordingly

2003 HOUSE JUDICIARY

SB 2271

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2271

House Judiciary Committee

☐ Conference Committee

Hearing Date 3-17-03

Tape Number	Side A	Side B	Meter #
1		xx	0-end
2	xx		0-2.9
2	xx		13.7-15
Committee Clerk Signature	CPenrose		

Minutes: 12 members present, 1 member absent (Rep. Galvin)

Chairman DeKrey: We will open the hearing on SB 2271.

Arnold Thomas, Health Association: Support, introduced the bill, which establishes rules for hospital and doctors to report use of intoxicants which may harm the mother and the unborn child. This bill came about initially from the hospitals and very quickly expanded to include voices and perspectives from the Dept. of Human Services, the Attorney General's office, the Peace Officers, County attorneys, Hospitals and State Medical Society. What you have here is the product of that collaborative effort. People coming behind me will be able to talk more specifically about what currently the reporting requirements are, how this bill relates to current statutes, also what the specifics are relative to what may or may not be done under the provisions of SB 2271, which we are asking for your favorable endorsement today.

Rep. Delmore: On page 3, it says any individual may make a voluntary report. Is that limited to those in the health and medical field. If I wanted to turn somebody in fraudulently, could I still do that.

Mr. Thomas: On page 3, you are talking about Section 2, item 2, there would be others better able to answer that. That is what we are trying to do, is to provide some clarity.

Chairman DeKrey: Thank you. Further testimony in support of SB 2271.

Jonathan Byers, Assistant AG: Support (see attached testimony). On the Senate side, a read a paragraph from a Law Review article that addresses the general nature of this bill. This is from the John Marshall Law Review and it is an article written by Julie Zatella. "A panoramic view of the hospital's nursery window was a picture perfect display of tranquil babies swathed in pink and blue blankets. Rebecca, a tiny baby girl in the corner, is not bundled in a pink blanket, but covered by a tangle of wires, tubes and machines. She is not sleeping, she is erratically jerking her arms and legs in the air, while piercing the maternity ward silence with her shrill screams. Rebecca was born underweight and premature with kidney deformities. Her pathetic shuddering and inconsolable shrieking screams will disappear after a few months, only to be replaced with listlessness and chronic diarrhea. By the age of 1, daycare workers will constantly watch this undersized baby girl, because she impulsively hits the other children. At the age 2, Rebecca will become so unusually fearful of everything that she will not make eye contact with anyone. She will become so hyperactive that she will touch everything and foster peculiar habits, such as eating cigarette ashes. She will develop into a mentally limited adult and will have problems interacting with other persons. Cocaine, the drug that gave this little girl's mother the shortest

tie, will achieve its longest legacy through Rebecca." The hypothetical example above is a prime illustration of the devastating problem of infants who are casualties before they are even born.

I first want to answer Rep. Delmore's question about whether people who are not in a medical field are required to report. The answer to that is yes. In this bill, even the neighbor can make a voluntary report. That's the same way it is with the Child Abuse and Neglect Reporting law as it is right now. Certain people are mandated to report, doctors, teachers, counselors, but anyone else can make a voluntary report and that's the same way that this is true. If they do make a report and it is fraudulent, they can be prosecuted for that, and if it is made in good faith, then they have immunity from prosecution for making the report.

Rep. Delmore: So within the bill, there are no ramifications... I certainly believe in prenatal care and see the importance of it. But the bill is just for people to go into treatment, especially if they are pregnant.

Mr. Byers: Yes, that's really what is behind this, is to get them into treatment. In fact, if you look on page 4 and page 6; page 4, subsection 4 towards the top middle of the page there, if report is made and normally then an assessment, an offering of services by social services, and possibly a mental health commitment if they don't comply. If a pregnant woman immediately enters a treatment program, that whole process can stop and as long as she stays in the treatment program, then Human Services is not wasting their time and resources doing investigations because the person has already done what is behind this, and that is getting into a treatment program.

Rep. Delmore: If I refuse, I say I don't have a problem, (in denial) or I really don't have a problem, and I'm sure that will happen, what happens if I say to these people who turned me in who think I need further treatment, what are the ramifications.

Mr. Byers: The first thing that happens is the assessment. The assessment is done to determine whether there are facts and other circumstances which would indicate that there is a problem, contrary to the denial of the person. So that assessment will either disclose if there still does seem to be a problem or you are right, you don't have a problem. Once that assessment is done, once the reports indicate that I do have an alcohol or drug problem, but I'm still not going to get treatment, the enforcement mechanism to all of this is a civil commitment under the mental health and alcohol and drug addiction chapters in the Century Code. That's the enforcement mechanism, not a prosecution but civil commitment for purposes of treatment.

Rep. Delmore: So I could be involuntarily committed.

Mr. Byers: Yes, at the very end result, if you refuse the services that are offered, you could be involuntarily committed.

Chairman DeKrey: You could be involuntarily committed now, right.

Mr. Byers: You could be under current law because of the drug and alcohol addiction.

Rep. Eckre: I know from reading over the past 10 years, a lot of the Native Americans tribes on the reservations have put some of their things into place, even locking people up during their whole pregnancy, or because of drug or alcohol, would this bill, the Tribes would still have their own right to do things, don't they.

Mr. Byers: Yes, they would have the ability to do what they are normally doing now. This provides a mechanism under state law.

Rep. Boehning: One question I've got, is nicotine. It's illegal to smoke under the age of 18, can you get girls under the age of 18, can we work with them with this bill.

Mr. Byers: This bill does not cover tobacco issues. I do have two or three law review articles that talk about some states that have even addressed illegal use of tobacco by underage persons. This wouldn't come into the purview of this statute by tobacco users.

Chairman DeKrey: Thank you. Further testimony in support.

Senator Lee: I fully support this bill. I shared their concern at the time that this subject was brought to me and want to make every effort that we can make to ensure that innocent children who are born at least have a fair chance of coming into the world healthy, and not being affected by some controlled substance, alcohol or drugs. So if there is a way that we can encourage in a very positive fashion, then it is worth it. We need to make sure that pregnant women are in a treatment program so that we can ensure not only their health but particularly the long range good health of the child. That's really important.

Rep. Delmore: If people who are on alcohol or these types of drugs, are not caught very early, will this really prevent anything as far as the child's development. Unless we get them very, very early, will this make a difference to them.

Sen. Lee: That's really a question for physicians to answer. I think we are all very aware that an extraordinary amount of development takes place early on in the development of that embryo and then fetus. Certainly it is important to do things as quickly as possible. There could still be some developmental issues that could be addressed in this case. I would prefer that that question be answered by a medical professional.

Chairman DeKrey: Thank you. Further testimony in support of SB 2271.

Amy Wald, LSW, Youthworks: Support (see attached testimony).

Rep. Kingsbury: I was wondering, when you do a pregnancy test, can you test for drugs?

Ms. Wald: I think I would have to refer that to a medical professional.

Mr. Byers: Under the bill, if you are talking about the mother herself, testing the mother, it would only be done with her consent or if you already have a sample for some other reason, you could test on that sample. You couldn't take one from her without her permission.

Rep. Kingsbury: You could go ahead and test on that sample without her consent.

Mr. Byers: Yes, that is what the bill provides for. I am comfortable with that, where I thought there might be a search and seizure problem if you actually took the sample from the mother without her consent.

Rep. Kretschmar: Have there been studies done, for example, a woman is an alcoholic, during pregnancy, she doesn't drink. Can you tell if that will cause problems.

Mr. Byers: As far as I know, the studies have all related to alcohol use during the pregnancy. I am not familiar with any studies that have shown that alcohol abuse a year before that would have any impact on the fetus.

Rep. Kretschmar: There is that effect during pregnancy?

Mr. Byers: During pregnancy, yes.

Chairman DeKrey: Thank you.

Rep. Delmore: Can you answer my question about the intervention time, if a woman is in her third trimester, and an alcoholic, do you know if it would make a huge amount of difference to put her into treatment at that stage of the game, as far as the effects on the baby.

Mr. Byers: I think the best I can do is to answer similar to what Sen. Lee said. The studies have indicated that the most development happens early in the fetus' development. However, I would say that by allowing voluntary reports by neighbors and other people who know this mom, that the chances of getting an early report and intervention at an early stage are much higher, because if friends and family know that she's pregnant and already in the third month, and using alcohol, I think intervention can happen.

Rep. Delmore: One of the things that I'm even more concerned about than this is just the lack of prenatal health. A lot of women can't afford health care and that's where we see lots and lots of problems. Who will pay for this scenario if a woman is asked to come in and be evaluated.

Mr. Byers: The costs of the assessments and the offering of services is in the Dept. of Human Services budget and someone will speak to that I imagine. The costs of the treatment, once they are committed to some type of treatment program, again will be through the State Hospital or a human service center, which would be under the Dept. of Human Services, as well.

Rep. Klemin: One of the problems that I've seen previously being on the board of directors for March of Dimes of ND, is that Fetal Alcohol Syndrome is one of their main issues and they are involved in prevention efforts. One of the problems I've seen on the reservations, there seems to be a large amount of alcoholism and that does result in FAS. Many times those mothers who are pregnant, but are on the reservation do go to see a doctor who is off the reservation. How is this going to work in multi-jurisdictional type of situation.

Mr. Byers: If the report based on a visit to a physician that's off the reservation and that petition can be filed with the person taking into custody while they are off the reservation. It shouldn't be a problem, I think there is personal jurisdiction over that. But the question would be if the report

is made, and the Native American individual gets back on the reservation, how are we going to enforce that. I guess we would have to take a look at that, and if there is any type of agreement that can be entered into by the parties. As Rep. Eckre indicated before, if they are already concerned enough to put people under lock-up, they are taking their own measures to try to stop that from happening. I would think that they would be receptive to talk about an intergovernmental agreement of a civil commitment of a Native American.

Rep. Klemin: I don't see this bill providing any thing like that now, but is it possible that under this bill, that it might have a detrimental effect to discourage proper prenatal care.

Mr. Byers: As I indicated, I think that that is a possibility. But if what is going to happen is, we're not going to do this and allow someone to get prenatal care, but they continue to use alcohol or drugs, what kind of prenatal care is that anyway. I mean the most important thing they can do is to stop that, no matter what else. The most important thing is to stop the drug and alcohol abuse. I think that weighs the balance scale in favor of having the law there, even if in a few cases, it deters someone from getting prenatal care.

Chairman DeKrey: Thank you. Further testimony in support.

John Olson, States Attorney of ND and Peace Officers Association: Support. I think some of the concerns that I have about the bill can be addressed by Karen Larson, Dept. of Human Services. I was involved on behalf of my group with the discussions that led to the crafting of SB 2271, and I appreciate that involvement. I have a few questions. In talking to Chip, the concerns probably could be addressed by amending the bill. I don't think that is appropriate. What I want to say to you involves our support for the bill. We think it is an excellent bill, we think that this is something that prevent defects, can prevent problems for children. This is every

bit as much child abuse as physical or mental abuse that people are required to report. So what I am appearing here today is try to establish a record of how we understand the bill and how we believe it can and should work. The bill itself creates some, I think, some need for understanding what alcohol abuse is and what drug abuse is. I think it goes beyond just a determination at the outset, that there is FAS that is going to be the ultimate end result in pregnancy, or that there is drug addiction. So let me call your attention to the provisions of this bill that I want to address. No. 1 on the first page, the abuse of alcohol, alcohol abuse, or abused alcohol get the definition. It means alcohol abuse or dependence as defined in the current DSM 4, published by the American Psychiatry Association, or a maladaptive use of alcohol with negative medical, sociological, occupational or familial effects. I don't know precisely what the first part of that definition means, and I get a little lost on the second part of that. Particularly when you have nonmedical trained personnel that have to make these judgments. The next provision that I think it is important to look at is page 2, the prenatal exposure to a controlled substance, means use of a controlled substance as defined in chapter 19-03.1 or any controlled substance that is listed and there is a whole host of them by a pregnant woman who a nonmedical purpose during pregnancy, as evidenced by withdrawal symptoms in a child at birth, results in a toxicology test performed on the mother at delivery of the child, at birth, or medical effects or developmental delays during the child's first year of life and medically indicate prenatal exposure to a controlled substance. That has a little bit more in the domain of medically trained personnel to make those determinations. The next section is on page 3, section 2, subsection 1, and that relates to the individual required to report and for your information, an individual that is required to report is listed in that section, 50-25.103, it sets forth a whole number of people who are subject to the

reporting requirements of child abuse and neglect now. What you are doing is expanding that same duty to report to those same categories of people. So if you have physicians, nurses, dentists, people on the medical profession, or any other medical or mental health professional, religious practitioner of the healing arts, school teachers, administrators, school counselors, addiction counselors, social workers, day care center providers, allow other people and police or law enforcement officers, or members of the clergy at a reasonable cause or knowledge to suspect that a child is getting abused. Here is the reporting requirement, an individual required to report under Section 50-25.103 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy shall file that report. So these seem to be a little more wide open than the definition. The next provision is on page 5, section 4, subsection 1. That section provides that an individual required to report under that section, who has knowledge of, or reasonable cause to suspect that a woman is pregnant and has abused alcohol after the woman knows of her pregnancy, then may make that report in the range for those things to be done. Other provisions currently in the code that give law enforcement some protection from liability, primarily based upon their lack of knowledge or understanding of some of these issues. .09 in that same chapter, which provides for immunity from liability based upon good faith. I am interpreting that section to not only mean that it is good faith for making the report, but also good faith for not making a report and I think that is important. Because if an officer misses that, and doesn't make a report is also a good faith compliance with the statutes. There are also other concerns that law enforcement officers may have, especially in the terms of drug investigations, where they know that pregnant women may be involved and using drugs. I think they will perceive their duty to even make a

report in those instances. At first blush, maybe they would have a concern about the integrity of the drug investigation, but I think that the fact that the reporting is confidential, pursuant to other provisions in this chapter, may give them comfort that because of the reporting, they should not be compromising the integrity of that drug investigation. I think my point here is, Mr. Chairman, and members of the committee, is that #1, I think that there needs to be a determination of good faith that may apply a different standard to those who are not medically trained from those who are. We're going to have questions come up, whether or not the law enforcement officer in the field who stops somebody for drunk driving and determines that that person is under the influence, is there a duty to report. I think that if you are going to say one is under the influence, and there is no first blush determination by the officer that this is not a chronic alcoholic, maybe there is going to be no report, but I think the point needs to be made that somehow we need to come together on the field operations of law enforcement and educating them in terms of when to make these reports. I think that maybe Karen Larson can address this, and I know that law enforcement, probably as much as medical providers, will be on the front line and very instrumental in making these assessments, either in their course of their investigations. They will be involved with juveniles, alcohol violations such as drunk driving or others in the field, involved with finding someone in possession of marijuana and whether or not that is going to trigger a duty to report. All of those questions need to be asked and they need to be answered. I don't think they can be addressed sufficiently in this bill, but they need to be addressed with the cooperative efforts of law enforcement with the Dept. of Medical Providers in making those crucial decisions at the outset. That's my point. I don't want to raise any objections to this bill, but I do want to establish for the record that there needs to be some of these issues addressed and

I think they can be addressed in training, in policy decisions that are communicated sufficiently to the people that I represent, the peace officers.

Rep. Grande: Take me to the scenario you were using earlier, the peace officer who has stopped someone for DUI, and pretty much assume that it is a pregnant woman, by visual inspection, she says she is pregnant, we have someone in a situation where, in our society we've all been taught and told that alcohol and pregnancy are not going to mix. Should this person be a suspect no matter what, would it not be best to err on the side of the safety of the child.

Mr. Olson: Absolutely. I would make that report. I don't know if that is one isolated incident of alcohol abuse, which is all the information that the officer is going to have at that point; but if that's the case, then I think that it should be clearly communicated to law enforcement that that report should be made. Upon conviction of a DUI, all offenders are given alcohol evaluation assessment. We are talking here about probable cause, a quick determination before guilt is established that there is an alcohol abuse going on at this time. I think you are right. I think if I were the law enforcement officer in the field, I would make a report that would go to DHS. What you raise is very important because that should become a standard reporting criteria that will affect the entire state.

Rep. Grande: I look at this as a clear means toward abuse of the child. Again, it goes back to are we going to report child abuse or not.

Mr. Olson: Keep in mind, a test could come back under the presumption of .10 or .08 and those kinds of questions are going to fog up this issue and they need to be addressed.

Rep. Delmore: You mentioned that earlier, will legislative intent of this bill be clear. We talk about that all the time, whether or not what we are passing out is the same as what we say and

hear during the hearing and when we are formulating its importance. Do you think there needs to be an amendment to make some of that.

Mr. Olson: I'm not comfortable making amendments. We had a really big discussion about this at our peace officer's in our last legislative committee meeting and some suggested, well this is going to create too many problems for us. We should be out. The dominant view was, and I share this view, no peace officers needs to be in. I don't think you can detail out in terms of an amendment how this should or can work. You need to rely on peace officers and working with the requirement of medical providers and coming up with I think criteria that should fly. I, of course, as an attorney, am worried about their liability if they do something wrong. I think we can address that with good faith that this is required to be established under the immunity statute.

Rep. Delmore: I can certainly empathize with what you are saying. I think that good faith is in there as well, that if someone, especially a professional, turns someone in, they will be protected.

Mr. Olson: I think that this bill really has potential for a lot of change in the way that we handle this issue in North Dakota, because of the people who are incorporated into the definition of who must report.

Chairman DeKrey: Thank you. Further testimony in support.

Karen Romig Larson, Director of Division of Mental Health and Substance Abuse in Dept. of Human Services: Support (see attached testimony). In response to the question on later intervention in pregnancy vs. early intervention. I have been a member of the ND Fetal Alcohol Syndrome Task Force for about 14 years and again I am extremely interested in this whole issue. The one thing that I can tell you, that with alcohol abuse that there are teratogenic effect, it means that it alters the development at all stages of pregnancy. First, Second and Third Trimester. So

the earlier the better, but you do create positive reactions at any time, even if it is the day before delivery. That is very important to know. With other drugs, there are a few controlled substances that have teratogenic effects, in terms of the actual cellular effect of those drugs and most of those of are in the barbituratory class, that can produce and there is a high incidence, for instance of heart defects, and also cleft lip and cleft palate when women abuse or use those drugs during pregnancy. Other drugs have more of a potential of probably not permanent, but long-standing behavioral, learning disability and, in fact, they do not create mental retardation. Meth., cocaine, heroin, all produce effects that include withdrawal from the drug after the baby is born, and then some ongoing learning disability and behavioral disability that we're working on.

Rep. Boehning: I guess what I want to know, what is considered abuse of alcohol when you're pregnant, one drink a day, two drinks a day, what is the limit and tolerance?

Ms. Larson: That's the $64,000 question. Basically what we have in this country, is the eastern school of thought and the western school of thought. The Univ. of Washington, which was the group of people that identified the cluster of symptoms that identified Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/FAE) basically stated that there had been no safe level of use of alcohol during pregnancy; which is to say that we don't know given other variables that might be present in that person's life, what produce FAS/FAE. On the other hand, the eastern school of thought, usually led by folks and researchers out of Harvard, that FAS is only likely to happen to somebody who really has a diagnosable level of alcohol abuse and more than likely to be alcohol dependent, which has its own set of symptoms. What we see is that kind of middle that says, that while we don't know of a safe level of drinking, abuse of alcohol is identified as using, probably, drinking more than two drinks a day for women. Having some outcomes that are less than

favorable which might include actually driving under the influence, legal problems, family problems, or some medical problems that might be related to the abuse of it.

Rep. Wrangham: Rep. Boehning asked my question.

Rep. Delmore: Are you comfortable with the idea that a sample could be tested without permission of the person.

Ms. Larson: We discussed this area at length as a group. Also in reviewing what has been happening in some other states and reading some of the work and wonderful research in the area of drug exposed infants by Dr. Ira Chaznow, who basically supports the fact that if you do have a sample of blood for other purposes, especially when you are moving towards intervention and treatment, is OK. Trying to take a sample just for the sole purpose of testing it without the mother's knowledge or permission is another matter and I think this bill balances that and protects them.

Rep. Delmore: Are there instances where there could be false positives on the test.

Ms. Larson: Always there is the likelihood, I would believe that the intent of this bill, part of the education would be that referral for further assessment by an addiction counselor would help to determine that. I also believe that the actual testing itself would be more than what we see with the present kinds of urine drug screening that is done that just indicates the presence or absence of something, which is much more likely to yield a false positive than a blood test.

Rep. Klemin: Who pays for the test?

Ms. Larson: I'm not sure, I would guess that it would depend on the insurance. I think we talked about that. We just determined that that would be a part of the care deliverer, depending on who was paying for it.

Rep. Klemin: So in the situation where the test is done without consent of the woman, and the specimen is not available, the person has health insurance, are we expecting the health insurance of the person would pay for it.

Ms. Larson: I think that would be assumption, but I don't think we detailed it down to that level. Arnold Larson: The discussion indicated that the financial sponsorship would bear the burden for the assessment; whether or not it was considered problematic. The cost and payment of this test is different than many other issues that are associated with this matter. This is one of those issues where we would start out and keep our eye on it and see where it goes. For those individuals who have no sponsorship, they are not eligible for Medicaid or have no other means of insurance... (could not hear because the speaker was not at the podium and the tape changed at that moment).

Rep. Delmore: Just one other thing I want to touch upon, concerning dealing with meth. which to me is even far beyond what probably even alcohol can do. Will this bill help us to get a better handle on young women who may be problem users of meth.

Ms. Larson: Absolutely. The one thing that I want to clarify is that FAS/FAE birth defects are permanent and irreversible. The early indications, and we don't have a long period of study and researching meth., is that with early intervention, behavioral and learning difficulties are likely reduced. But the earlier the better and this bill will very much help that.

Rep. Kretschmar: How prevalent in that problem in ND - FAS.

Ms. Larson: It is difficult to determine the exact level at which that is happening because we don't have an accurate reporting mechanism. The state of ND is part of a four state consortium that, through the efforts of former Lt. Gov. Rosemary Myrdahl, put together a research group,

MN, MT, SD and ND, and were able to achieve multi-state funding from the Center for Substance Abuse/Prevention to take a look at how we might better be able to gather more accurate statistics because number 1 you may not see the reporting on the birth certificate, and even following that we don't have a pure mechanism for a recording of the incidents and prevalence. We have some guesses and we have at least the known folks in the state and I can certainly provide this committee with a snapshot of that from our FAS center in Grand Forks.

Rep. Boehning: What are the effects of nicotine or smoking on the fetus, what are the effects of that.

Ms. Larson: The principal effect of continued tobacco use and nicotine exposure to an infant during pregnancy is the likelihood of premature birth and/or if taken to term, low-birth weight.

Chairman DeKrey: Thank you. Further testimony in support. Testimony in opposition. We will close the hearing.

(Reopened later in the same session)

Chairman DeKrey: What are the committee's wishes in regard to SB 2271.

Rep. Grande: I move a Do Pass.

Rep. Kingsbury: Seconded.

10 YES 0 NO 3 ABSENT DO PASS CARRIER: Rep. Delmore

Date: 3/17/03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2271

House Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Rep. Grande Seconded By Rep. Kingsbury

Representatives	Yes	No	Representatives	Yes	No
Chairman DeKrey	✓		Rep. Delmore	✓	
Vice Chairman Maragos	AB		Rep. Eckre	✓	
Rep. Bernstein	✓		Rep. Onstad	✓	
Rep. Boehning	✓				
Rep. Galvin	AB				
Rep. Grande	✓				
Rep. Kingsbury	✓				
Rep. Klemin	✓				
Rep. Kretschmar	✓				
Rep. Wrangham	AB				

Total (Yes) 10 No 0

Absent 3

Floor Assignment Rep. Delmore

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 17, 2003 12:14 p.m.

Module No: HR-47-4901
Carrier: Delmore
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2271, as engrossed: Judiciary Committee (Rep. DeKrey, Chairman) *recommends* **DO PASS** (10 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). Engrossed SB 2271 was placed on the Fourteenth order on the calendar.

2003 TESTIMONY

SB 2271

Att #1

Prepared by the North Dakota Healthcare Association
February 9, 2003

PROPOSED AMENDMENTS TO SENATE BILL NO. 2271

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to

A BILL for an Act to create and enact three new sections to chapter 50-25.1 of the North Dakota Century Code, relating to prenatal testing and reporting; and to amend and reenact section 50-25.1-02 of the North Dakota Century Code, relating to child abuse and neglect reporting requirements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-25.1-02 of the North Dakota Century Code is amended and reenacted as follows:

50-25.1-02. Definitions.
1. "A person responsible for the child's welfare" means the child's parent, guardian, or foster parent; an employee of a public or private school or nonresidential child care facility; an employee of a public or private residential home, institution, or agency; or a person responsible for the child's welfare in a residential setting.

2. "Abuse of alcohol", "Alcohol Abuse" or "Abused Alcohol" means alcohol abuse or dependence as defined in the current diagnostic and statistical manual published by the american psychiatric association or a maladaptive use of alcohol with negative medical, sociological, occupational or familial effects.

3. "Abused child" means an individual under the age of eighteen years who is suffering from serious physical harm or traumatic abuse caused by other than accidental means by a person responsible for the child's welfare, or who is suffering from or was subjected to any act involving that individual in violation of sections 12.1-20-01 through 12.1-20-08.

~~3.~~ 4. "Assessment" means a factfinding process designed to provide information that enables a determination to be made that services are required to provide for the protection and treatment of an abused or neglected child.
~~4.~~ 5. "Department" means the department of human services or its designee.
~~5.~~ 6. "Harm" means negative changes in a child's health which occur when a person responsible for the child's welfare:
a. Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or
b. Commits, allows to be committed, or conspires to commit, against the child, a sex offense as defined in chapter 12.1-20.
~~6.~~ 7. "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential

facility owned or managed by the state or a political subdivision of the state.
~~7.~~ 8. "Local child protection team" means a multidisciplinary team consisting of the designee of the director of the regional human service center, together with such other representatives as that director might select for the team with the consent of the director of the county social service board. All team members, at the time of their selection and thereafter, must be staff members of the public or private agencies they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three members. The department shall coordinate the organization of local child protection teams on a county or multicounty basis.
~~8.~~ 9. "Neglected child" means a deprived child as defined in chapter 27-20.
~~9.~~ 10. "Prenatal exposure to a controlled substance" means use of controlled substances as defined in Chapter 19-03.1 by a pregnant woman for a nonmedical purpose during pregnancy as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.
11. "Protective services" includes services performed after an assessment of a report of child abuse or neglect has been conducted, such as social assessment, service planning, implementation of service plans, treatment services, referral services, coordination with referral sources, progress assessment, monitoring service delivery, and direct services.
~~10.~~ 12. "State child protection team" means a multidisciplinary team consisting of the designee of the department and, where possible of a physician, a representative of a child-placing agency, a representative of the state department of health, a representative of the attorney general, a representative of the superintendent of public instruction, a representative of the department of corrections and rehabilitation, one or more representatives of the lay community, and, as an ad hoc member, the designee of the chief executive official of any institution named in a report of institutional abuse or neglect. All team members, at the time of their selection and thereafter, must be staff members of the public or private agency they represent or shall serve without remuneration. An attorney member of the child protection team may not be appointed to represent the child or the parents at any subsequent court proceeding nor may the child protection team be composed of fewer than three persons.

SECTION 2. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to controlled substances – Reporting requirements.

1. A person required to report under 50-25.1-03 subsection 1 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose, during the pregnancy shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.

2. Any person may make a voluntary report if the person has knowledge of or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose, during the pregnancy.
3. If a report alleges a pregnant woman's use of a controlled substance for a nonmedical purpose, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under Chapter 25-03.1, including seeking an emergency admission under Section 25-03.1-25.
4. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, a person required to report under 50-25.1-03 subsection 1,who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.
5. A report under this section must be made as described in 50-25.1-04, and must be sufficient to identify the woman, the nature and extent of use, if known, and the name and address of the reporter.

SECTION 3. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Toxicology testing - Requirements

1. Upon the consent of the pregnant woman or, without consent if a specimen is otherwise available, a physician shall administer a toxicology test to a pregnant woman under the physician's care or to a woman under the physician's care within eight hours after delivery to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a nonmedical purpose. If the test results are positive, the physician shall report the results under section 50-25.1-03.1. A negative test result or the pregnant woman's refusal to consent to a test, does not eliminate the obligation to report under section 50-25.1-03.1, if other evidence gives the physician reason to believe the patient has used a controlled substance for a nonmedical purpose.

2. A physician shall administer, without the consent of the child's parents or guardian, to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy. If the test results are positive, the physician shall report the results as neglect under section 50-25.1-03. A negative

test result does not eliminate the obligation to report under section 50-25.1-03 if other medical evidence of prenatal exposure to a controlled substance is present.

3. Immunity from liability. A physician or other medical personnel administering a toxicology test to determine the presence of a controlled substance in a pregnant woman, in a woman within eight hours after delivery, or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test, if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice. A physician or other medical personnel who determines in good faith not to administer a toxicology test under this section is immune from liability for not administering the test.

SECTION 4. A new section to chapter 50-25.1 of the North Dakota Century Code is created and enacted as follows:

Prenatal exposure to alcohol abuse – Reporting requirements.

1. A person required to report under subsection 1 of section 50-25.1-03 who has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol after she knows of the pregnancy may:
   a. Arrange for a chemical dependency assessment conducted by a licensed treatment program and confirm that the recommendations indicated by the assessment are followed; or
   b. Immediately report the circumstances to the department, if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.
2. Any person may make a voluntary report if the person has knowledge of or reasonable cause to suspect that a woman is pregnant and has abused alcohol during the pregnancy.
3. If the woman is referred for a chemical dependency assessment under subdivision a of subsection 1 and fails to obtain an assessment or refuses to comply with the recommendations of the assessment, a person required to report under subsection 1 of section 50-25.1-03 who has knowledge of the failure to obtain the assessment or refusal to comply with recommendations of the assessment shall make a report to the department.
4. If a report alleges a pregnant woman has abused alcohol, the department or its designee shall immediately initiate an appropriate assessment and offer services indicated under the circumstances. Services offered may include a referral for chemical dependency assessment, a referral for chemical dependency treatment, if recommended, or a referral for prenatal care. The department or its designee may also take any appropriate action under Chapter 25-03.1, including seeking an emergency admission under Section 25-03.1-25.

5. A report and assessment under this section is not required if the pregnant woman voluntarily enters treatment in a licensed treatment program. If the pregnant woman does not complete voluntary treatment or fails to follow treatment recommendations, a person required to report under 50-25.1-03 subsection 1 who has knowledge of the failure to complete voluntary treatment or failure to follow treatment recommendations shall make a report as required by this section.
6. A report under this section must be made as described in section 50-25.1-04, and must be sufficient to identify the woman, the nature and extent of the abuse of alcohol, any health risk associated with the abuse of alcohol, and the name and address of the reporter. "

Renumber accordingly

AH #2

Senate Bill 2271

Testimony provided by Amy Wald

February 11, 2003

Good morning Chairman Traynor and committee memebers. My name is Amy Wald. I am a Licensed Social Worker at Youthworks. Youthworks is a non-profit agency that services at risk youth and their families. I work in the capacity of an outreach coordinator, providing services to approximately 100 youth and families over the course of a year. I have worked in this capacity for approximately three years.

In my four-year career as a social worker, I have come into contact with approximately thirty children who live with Fetal Alcohol Syndrome or Fetal Alcohol Effect. Their abnormalities can be seen in the areas of growth, performance, craniofacial, skeletal and cardiac. Some common and outward symptoms include low set ears, wider set eyes, cleft lip and a short neck, to name a few. These children average an I.Q. of 63, which is the mental retardation range. The majority of children I have served are very aware of their condition and the differences between them and other children. They face daily challenges. My contact with them tends to be around behavioral concerns. These children have poor judgment, distractibility and difficulty recognizing social cues. Children with FAS/FAE also have difficulty with consequential thinking. All of this poses a great challenge in dealing with consequencing behaviors.

I am here today to provide testimony in support of Senate Bill 2271. The driving force in my testimony is centered around a family in which I quickly realized my hands were tied. My role in this case was to deal with a young female who had received a juvenile citation.

During the intake process, the girl's mother disclosed to me that she was in her 3rd trimester of her pregnancy. She reported that she had previously been through a treatment program but was currently an active drinker. She disclosed she was consuming a large amount of alcohol on a regular basis. I immediately spoke to her regarding Fetal Alcohol Syndrome. She defiantly responded that she knew the dangers, but is an alcoholic.

The week after the intake I met with the girl at her local school. She looked at me with pain in her eyes and a level of seriousness that I will never forget. She stated that she would cooperate with me; but she knew that I would not be able to help her family. She stated a number of social workers and licensed addiction counselors could not "fix my mom and neither will you."

In the course of my work with this family, I accessed a number of agencies to address this matter. At the local level a child abuse and neglect report was made. This report was followed by a number of phone calls updating the Child

Protection Worker. The worker was repeatedly informed that the mother was continuing to drink. The worker reported that there was nothing they could do.

I was unhappy with this decision and contacted the juvenile court. The court informed me there was not a statute in place to deal with this issue. I couldn't believe it. It seemed as though the teenager was right, there was nothing I could do to help her mother or her unborn baby brother or sister. I then contacted the West Central Humane Service Center. There, too, I was met with the same answer, that there is nothing we can do.

In the next few weeks, I continued to search for an answer and someone who could help with my dilemma. While in the Bismarck office, I staffed this case with a co-worker. I had explained each avenue I had pursued. He suggested calling the state administrator of Child Abuse and Neglect. Consulting with this office finally opened a door and I was able to do something to help my client and her family. Although there was nothing immediately they could do, I was informed about the possibility of testifying on this bill. This is why I am here today.

The baby was born with clear symptoms of FAS/FAE such as lower than the normal birth weight, low set ears, eyes set far apart, cleft lip and a heart defect.

I believe that my client's mother suffered from a terrible disease called alcoholism. She had been through a treatment program and did successfully complete. She was able to maintain sobriety for a period of time. I believe if she could have gone through detox and had the treatment and support she needed, she would have been able to think clearly.

For the case I have spoken about today, there are no words to describe the pain and challenges the family will forever endure. The saddest part is that it is preventable! My main request today is that we as service providers have some options in dealing with preventable diseases. Specifically an alcohol addicted pregnant woman and the risk of a FAS/FAE child.

In further support of this bill I would like to take a moment to address monetary issues. It seems ridiculous to go from talking about a family's real life story and hardships to speaking about dollars and cents. However, the truth is, by passing legislation like this, it will save the state a considerable amount of money. A few months of inpatient treatment would be minimal compared to potentially weeks or even months in the NICU neonatal (intensive care unit) and life long bills centered around medical, education and even legal issues.

Thank you

AH #3

SENATE BILL 2271 TESTIMONY
SENATE JUDICIARY COMMITTEE
FEBRUARY 12TH, 2003
FORT LINCOLN ROOM

By Jonathan Byers, Assistant Attorney General

Mr. Chairman and Members of the Committee:

My name is Jonathan Byers and I appear on behalf of the Attorney General. I wish to testify in favor of Senate Bill 2271.

The Federal government calculates that an infant prenatally exposed to illegal drugs costs society about $1 million over its lifetime. Richard Whitmire, *Drug-Using Pregnant Women: Medical or Criminal Problem?* Gannett New Service, Mar. 30, 1994, at 1, available in 1994 WL 11251843. This begs the question: How widespread is the problem?

Already in the early 1990's, before meth really exploded on America's streets, studies were showing that one in every ten fetuses in the United States was exposed to cocaine in the womb. Cynthia Glaze, Combating Prenatal Substance Abuse: *The State's Current Approach and the Novel Approach of Court-ordered Protective Custody of the Fetus*, 80 Marq. L. Rev. 793 (1997). Eleven percent of pregnant women were using some form of controlled substance. Researchers estimate that the figures are closer to 15 to 20 percent in urban areas. C. Antoinette Clarke, *FINS, PINS, CHIPS, and CHINS: a Reasoned Approach to the Problem of Drug Use During Pregnancy*, 29 Seton Hall L. Rev. 634 (1998).

Yesterday Senator Dever posed the question whether the toxicology testing and mandated reporting will have a deterrent effect on pregnant moms seeking prenatal care. That may happen in some instances. But what good is prenatal care if the mother continues to drink everyday or use controlled substances? Senate Bill 2271 does not threaten the mother with criminal prosecution; it simply paves the way for entry into treatment, which may be the biggest step in prenatal care the mother can take.

The Attorney General asks for a do pass. I would be happy to answer any questions.

Att #4

TESTIMONY
SB 2271
SENATE JUDICIARY COMMITTEE
JOHN TRAYNOR, CHAIRMAN
FEBRUARY 11, 2003

Chairman Traynor and members of the Senate Judiciary Committee, my name is Karen Romig Larson, Director of the Division of Mental Health and Substance Abuse in the Department of Human Services. I am here today to speak to SB 2271.

I did have the opportunity to review, comment on, and make suggestions on the treatment-related portions of the proposed legislation. I feel confident that the proposed amendments reflect appropriate referral, assessment, and treatment direction.

48% Grant Money

In its acceptance of the Substance Abuse Prevention and Treatment Block Grant (SAPT) to provide services through the regional Human Service Centers, the Department must comply with the expectation that pregnant women who are abusing alcohol and other drugs will receive priority consideration in accessing appropriate treatment at the Centers. This legislation appears to support that effort.

It is apparent that there will be need to provide information and education to a number of disciplines regarding this legislation, if adopted. The Division of Mental Health and Substance Abuse is prepared to assist in whatever manner necessary.

Thank you for the opportunity to appear before you today. I will answer any questions you may have.

AH #5

North Dakota 2003 Legislative Session

Senate-Senate Committee on Judiciary

Senate Bill 2271

February 11, 2003

Chairperson Traynor and Members of the Committee:

My name is Dr. Ron Miller. I am a pediatrician and Medical Director of Children's Hospitals and Clinics at MeritCare Health System in Fargo, ND. I am submitting this testimony on behalf of MeritCare Health System in support of SB 2271. I strongly encourage the committee to bring SB 2271 to the floor of the Senate with a DO PASS recommendation.

MeritCare Health System supports the provisions provided in SB 2271 which will allow physicians to report prenatal exposure to controlled substances by the mother, the physicians to perform toxicology tests, and report prenatal exposure to alcohol abuse under NDCC chapter 50-25.1.

MeritCare provides comprehensive care for children throughout eastern North Dakota. The Children's Hospital sees more than 1,000 admissions to the hospital per year and over 20,000 pediatric visits per year. Pediatricians and family practitioners provide quality care to their patients, performing their duties with the children's interest in mind.

At the present time, physicians can perform prenatal tests with the consent of the mother. SB 2271 would allow the physicians who have reasonable cause or knowledge to suspect activities such as drug use or alcohol abuse to make a medical assessment to determine whether further tests are necessary. North Dakota law currently prohibits physicians from performing these tests without the mother's consent.

With the recent growth in methamphetamine and other illicit drug use and alcohol abuse in the state of North Dakota, these tests are imperative to provide high quality of care during the prenatal stages as well as to ensure the quality of health after the child is born. By performing these tests, physicians are able to assess the necessary level of care and intervention in order to provide the child with the best possible outcomes, particularly given the compromising and complex health these children are faced with.

The physicians in the state of North Dakota wish to provide quality care to their patients. By allowing the physicians the ability to do these tests, the physicians could provide a better quality of life for the child and the mother.

MeritCare strongly urges a DO PASS recommendation on SB 2271 to enable hospitals and physicians the ability to provide necessary and appropriate medical care.

TESTIMONY

SB 2271

HOUSE JUDICIARY COMMITTEE

DUANE DEKREY, CHAIRMAN

MARCH 17, 2003

Chairman DeKrey and members of the House Judiciary Committee, my name is Karen Romig Larson, Director of the Division of Mental Health and Substance Abuse in the Department of Human Services. I am here today to speak to SB 2271.

I did have the opportunity to review, comment on, and make suggestions on the treatment-related portions of the proposed legislation. I feel confident that the proposed amendments reflect appropriate referral, assessment, and treatment direction.

Senate Approved

In its acceptance of the Substance Abuse Prevention and Treatment Block Grant (SAPT) to provide services through the regional Human Service Centers, the Department must comply with the expectation that pregnant women who are abusing alcohol and other drugs will receive priority consideration in accessing appropriate treatment at the Centers. This legislation appears to support that effort.

It is apparent that there will be need to provide information and education to a number of disciplines regarding this legislation, if adopted. The Division of Mental Health and Substance Abuse is prepared to assist in whatever manner necessary.

Thank you for the opportunity to appear before you today. I will answer any questions you may have.

SENATE BILL 2271 TESTIMONY
HOUSE JUDICIARY COMMITTEE
MARCH 17TH, 2003
PRAIRIE ROOM

By Jonathan Byers, Assistant Attorney General

Mr. Chairman and Members of the Committee:

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The question may be raised whether the toxicology testing and mandated reporting will have a deterrent effect on pregnant moms seeking prenatal care. That may happen in some instances. But what good is prenatal care if the mother continues to drink everyday or use controlled substances? Senate Bill 2271 does not threaten the mother with criminal prosecution; it simply paves the way for entry into treatment, which may be the biggest step in prenatal care the mother can take.

The Attorney General asks for a do pass. I would be happy to answer any questions.

Senate Bill 2271

Testimony provided by Amy Wald

March 17, 2003

Good morning Chairman DeKray and committee memebers. My name is Amy Wald. I am a Licensed Social Worker at Youthworks. Youthworks is a non-profit agency that services at risk youth and their families. I work in the capacity of an outreach coordinator, providing services to approximately 100 youth and families over the course of a year. I have worked in this capacity for approximately three years.

In my four-year career as a social worker, I have come into contact with approximately thirty children who live with Fetal Alcohol Syndrome or Fetal Alcohol Effect. Their abnormalities can be seen in the areas of growth, performance, granlofacial, skeletal and cardiac. Some common and outward symptoms include low set ears, wider set eyes, cleft lip and a short neck, to name a few. These children average an I.Q. of 63, which is the mental retardation range. The majority of children I have served are very aware of their condition and the differences between them and other children. They face daily challenges. My contact with them tends to be around behavioral concerns. These children have poor judgment, distractibility and difficulty recognizing social cues. Children with FAS/FAE also have difficulty with consequential thinking. All of this poses a great challenge in dealing with consequencing behaviors.

I am here today to provide testimony in support of Senate Bill 2271. The driving force in my testimony is centered around a family in which I quickly realized my hands were tied. My role in this case was to deal with a young female who had received a juvenile citation.

During the intake process, the girl's mother disclosed to me that she was in her 3rd trimester of her pregnancy. She reported that she had previously been through a treatment program but was currently an active drinker. She disclosed she was consuming a large amount of alcohol on a regular basis. I immediately spoke to her regarding Fetal Alcohol Syndrome. She defiantly responded that she knew the dangers, but is an alcoholic.

The week after the intake I met with the girl at her local school. She looked at me with pain in her eyes and a level of seriousness that I will never forget. She stated that she would cooperate with me; but she knew that I would not be able to help her family. She stated a number of social workers and licensed addiction counselors could not "fix my mom and neither will you."

In the course of my work with this family, I accessed a number of agencies to address this matter. At the local level a child abuse and neglect report was made. This report was followed by a number of phone calls updating the Child

Protection Worker. The worker was repeatedly informed that the mother was continuing to drink. The worker reported that there was nothing they could do.

I was unhappy with this decision and contacted the juvenile court. The court informed me there was not a statute in place to deal with this issue. I couldn't believe it. It seemed as though the teenager was right, there was nothing I could do to help her mother or her unborn baby brother or sister. I then contacted the West Central Human Service Center. There, too, I was met with the same answer, that there is nothing we can do.

In the next few weeks, I continued to search for an answer and someone who could help with my dilemma. While in the Bismarck office, I staffed this case with a co-worker. I had explained each avenue I had pursued. He suggested calling the state administrator of Child Abuse and Neglect. Consulting with this office finally opened a door and I was able to do something to help my client and her family. Although there was nothing immediately they could do, I was informed about the possibility of testifying on this bill. This is why I am here today.

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In further support of this bill I would like to take a moment to address monetary issues. It seems ridiculous to go from talking about a family's real life story and hardships to speaking about dollars and cents. However, the truth is, by passing legislation like this, it will save the state a considerable amount of money. A few months of inpatient treatment would be minimal compared to potentially weeks or even months in the NICU neonatal (intensive care unit) and life long bills centered around medical, education and even legal issues.

Thank you

John Marshall Law Review
Spring 1996

Note

*765 PROTECTING OUR CHILDREN: A CALL TO REFORM STATE POLICIES TO HOLD PREGNANT DRUG ADDICTS ACCOUNTABLE

Julie J. Zitella

Introduction

A panoramic view of the hospital's nursery window is a picture-perfect display of tranquil babies swaddled in pink and blue blankets. [FN1] Rebecca, a tiny baby girl in the corner, is not bundled in a pink blanket but covered by a tangle of wires, tubes and machines. She is not sleeping; she is erratically jerking her arms and legs in the air while piercing the maternity ward's silence with a shrill scream. Rebecca was born underweight and premature with kidney deformities. [FN2] Her pathetic shuddering and inconsolable shrieking screams will disappear after a few months, only to be replaced with listlessness and chronic diarrhea. [FN3] By the age of one, daycare center workers will constantly watch this undersized baby girl because she impulsively hits the other children. [FN4] At the age of two, Rebecca will become so unusually fearful of everything that she will not make eye contact with anyone. [FN5] She will become so hyperactive that she will touch everything and foster peculiar habits, such as eating cigarette ashes. [FN6] She will develop into a mentally limited adult and will have problems interacting with other persons. [FN7] Cocaine, the drug that gave this little girl's mother the shortest high, will achieve its longest legacy through Rebecca. [FN8]

The hypothetical example above is a prime illustration of the devastating problem of infants who are casualties before they are born. [FN9] This Note argues that state policies currently do not protect *766 the interests of drug-exposed children and are therefore in need of reform. Part I of this Note examines the cocaine problem among women in the United States and the traumatic effects it has on their children. Parts II and III analyze the current civil and criminal responses of various state courts and legislatures to manage the problem of drug-addicted infants. Finally, Part IV proposes a change in state laws that will effectively protect and provide drug-addicted children a chance to live a nor mal, stable life.

I. Cocaine and Its Effects

First, this Part analyzes the history of cocaine use in the United States among women. This Part also discusses the effects that cocaine imposes on a child who is exposed in utero. Specifically, this Part examines the immediate effects of cocaine use on the infant, as well as possible long term behavioral and developmental effects the child may experience.

A. Who Is The Cocaine Mother?

The problem of substance abuse by pregnant mothers rose quickly during the 1980s when crack, the smokable form of cocaine, became available. [FN10] Crack is a high-potency, low-cost and highly addictive drug; it became the drug of choice for many pregnant women because it is the quickest acting and easiest form of cocaine to use since it is smoked, rather than injected or sniffed. [FN11] More than 100 cocaine-addicted babies are born each day; [FN12] one out of every ten newborns has been exposed to illegal *767 drugs in utero. [FN13]

The use of illegal substances during pregnancy occurs at all racial and socioeconomic levels. [FN14] The children of the crack generation range from poor, black ghetto children to white upper and middle class children. [FN15] Poor minority children have attracted more attention because cocaine abuse in white upper and middle classes is not frequently reported. [FN16] A 1989 Florida study discovered that, while the rates of drug use among pregnant black and white women of equal socioeconomic class were the same, only one percent of white abusers were reported to authorities, as com pared to ten percent of the black abusers. [FN17] Although the statistics may not accurately reflect the number of drug abusing mothers, this growing problem is invading every corner of America and affecting our youth.

B. The Effects Of Cocaine On The Fetus

Cocaineingested by a pregnant woman reaches the fetal circulation system by crossing the placenta. [FN18] Once the drug enters the fetus' system, it is converted into a more powerful sub stance, narcocaine, which remains in the fetus' system longer than in the mother's system. [FN19] This substance causes a constriction of the blood flow to the fetus and a corresponding decrease in the flow of oxygen to the fetus' developing vital organs, especially the brain. [FN20] The common consequences of maternal cocaine use include *768 premature birth, impaired fetal growth and neonatal seizures. [FN21] Many of these babies exhibit irritability, [FN22] lethargy and unresponsiveness to stimuli. [FN23] Specifically, cocaine-addicted children commonly exhibit jerking motions and piercing wails. [FN24] More gruesome consequences may also result, such as a shriveled arm or leg, a missing section of an organ or other deformities. [FN25] Other serious, disabling repercussions include heart defects, bleeding brains [FN26] and respiratory disorders. [FN27]

Although the tremors and other symptoms will dissipate after three or four months, [FN28] the consequences of maternal cocaine use may unfortunately extend to later periods of the child's life. Sever al long-term studies suggest that drug-exposed babies are at risk for later developmental problems and learning deficiencies. [FN29] Evidence shows that children exposed to drugs in utero are disorganized, rowdy and violent in the classroom. [FN30] Additionally, language *769 production and comprehension, recognition memory and regulation of arousal and attention states can be critically affect ed. [FN31]

The "crack generation," however, does not have to be the "lost generation." [FN32] Their history of drug exposure can neither be dismissed, nor held against them. [FN33] These innocent children have a chance of leading reasonably normal lives with appropriate and timely postnatal intervention. [FN34]

The Slavin Special Education Center, a leading organization in Los Angeles that works with older children who have been prenatally exposed to drugs, reports promising outcomes. [FN35] More than half of the center's students eventually transfer to main stream school classes, assisted by tutoring and counseling. [FN36] An other Californ'a study documents similar positive results. [FN37] For instance, one second grade drug-exposed student underwent a "metamorphosis from a non-communicative face constantly hidden under a hood to a smiling little boy full of curiosities." [FN38] In short, these children are not hopeless. Has the system, however, given up hope on these innocent lives?

*770 II. The Civil Liability Imposed On Drug-Abusing Mothers

Justice demands the "recognition of the legal right of every human being to begin life unimpaired by physical, mental or emotional defects resulting from the neglectful acts of the parent." [FN39] State intervention in domestic relations because of neglectful parents may be an unhappy but necessary aspect of life in our organized society. [FN40] Although the painful problem of child abuse and neglect has found no fully satisfactory solution, continued state intervention has produced promising progress. [FN41]

This Part discusses the civil liability placed on a woman who uses drugs while pregnant. This Part also analyzes the negative effects on the children when states impose civil liability on moth ers. Specifically, this Part will examine the problems that exist in the foster care system and in parental termination proceedings.

A. Child Abuse and Neglect Statutes

In response to the growing number of mothers giving birth to drug-addicted children, many states have intervened by imposing civil penalties on women who use drugs while pregnant. States have enacted laws that clearly define prenatal drug use as evi dence of child abuse or neglect. [FN42] Additionally, all states have *771 reporting laws that mandate certain persons, such as physicians, nurses, emergency room personnel and social workers, to report suspected child abuse and neglect to social service agencies. [FN43] For example, a physician is under a duty to immediately report the birth of a child who screens positive for drugs to a social ser vice agency; the agency will subsequently investigate the re port. [FN44] In Illinois, an obstetrician will report a finding of a drug- addicted child to the Department of Child and Family Services (DCFS). [FN45]

Immediately following birth, the state's social service agency may determine that the drug-exposed newborn is not in immediate danger; consequently, the agency will send the newborn home from the hospital with the family on a service plan [FN46] until an adjudicatory hearing. [FN47] If the family complies with the plan, the infant remains at home. [FN48] If, however, the social service agency *772 determines that either the family has not followed the rehabilitative plan, the family is dysfunctional or the safety of the child is in question, the state agency takes custody of the child until an adjudicatory hearing. [FN49]

After the agency files a petition alleging that a minor is abused or neglected, an adjudicatory hearing is held within 180 days after the date of service of process upon the minor and parents. [FN50] The court, at the dispositional hearing, reviews the effectiveness of past services aimed at family preservation and reunification. [FN51] In Illinois, the purpose of the adjudicatory hearing is to act in a just and speedy manner to (1) determine the best interests of the minor, (2) identify families in need, and (3) reunify families where it is in the best interests of the minor. When it is not in the best interest of the minor to be reunified with his *773 parents, the court will find another permanent home for him. [FN52]

If the provided services successfully reunify the family, the judge will award custody of the infant to the natural parents and close the case. [FN53] The most common outcome of the adjudicatory hearing, however, is a determination by the court that the best interest of the infant would be served by removing the infant from the custody of the natural parents. [FN54] The court will also deter mine whether to place the child in the custody of a suitable relative or to commit the child to an agency for care. [FN55] Ostensibly, the most important consideration throughout all of these procedures is the best interest of the child.

B. Problems With Imposing Civil Liability On Drug-Addicted Mothers

Those involved in creating policies related to perinatal drug addiction consider the child abuse, neglect and custody laws effective measures for protecting a child's best interests, altering maternal behavior and preserving the family unit. [FN56] The disturbing reality shows, however, that these laws do note achieve even one of these goals. [FN57] One reason why the state does not achieve its goals is because the courts frequently balance the parent's

interest in remaining a parent against the child's interest of living in a stable home. [FN58] Some courts consider the child's best interests as only one of the many factors of consideration in a case of such delicate nature. [FN59] A child's best interest, however, is not part of *774 any equation and is not to be balanced against any other interest. [FN60] "A child's best interest is and must remain inviolate and impregnable from all other factors, including the interests of the biological parents." [FN61]

1. The Foster Care Drift

Where, in fact, do the child's best interests lie? The best interests of the child are often found to be closely aligned with the best interests of the mother. [FN62] Most of the babies exposed to drugs, however, are almost automatically torn from their natural mother and sent to foster care. [FN63] However, the ultimateconsequence of ordering the separation of the parent and drug addicted infant by placing him in the foster care system is usually negative. [FN64]

To understand the problem with sending drug-exposed infants to foster care, the current foster care system must be evaluated. Currently, there are approximately 500,000 children in the foster care system, with over 55,000 in Chicago and surrounding Cook County alone. [FN65] The vast majority of these children are placed in and out of various foster homes while the biological mother attempts to get her life together. [FN66] After spending years in the foster care system, the child most commonly loses contact with his natural parents. [FN67] Typically, the child is alone and with out a chance to form a close relationship with any parental figure. [FN68] Specialists in the system label this the "foster care *775 drift." [FN69]

When a child enters foster care, the biological parent cedes custody of the child to the state's child welfare system. [FN70] The state's duty is to provide both the child and the parents with services designed to resolve the problem that originally separated them. [FN71] In most cases, however, state agencies offer few parents any help while their children are in foster care. [FN72] In fact, case workers do not regularly contact the natural parents. [FN73] The con tact between the natural mother and agency often drastically de creases after the first year of placement of the child in foster care. [FN74] This estrangement between the natural parents and child is not in the child's best interest because frequent contact between the agency, natural parent and child increases the chances that the child will return home during the first year of placement. [FN75]

When the state places a drug-addicted baby in the foster care system, the state may have custody of the child, but the natural mother still retains her parental rights. [FN76] Consequently, the foster care system traps tens of thousands of abused and neglected babies who are not free to be adopted into a stable family. [FN77] The biological mother is given multiple chances by the state to prove that she is fit to have legal custody of her child while her baby is bounced from foster home to foster home. [FN78] For example, when a *776 judge sees a mother who has failed her drug treatment, she is likely to insist that the mother enter every drug treatment pro gram available before deciding that the offered services did not resolve the problem. [FN79] Actually, while the natural mother clings to her parental rights, [FN80] her child will, on average, live with three different families. [FN81]

It is not uncommon for a foster child to live in ten or more foster homes. [FN82] To make matters worse, many social service agencies do not ensure that a child will be placed into a stable foster home. [FN83] Frequently, the agency "haphazardly" matches the child withthe foster home, which consequently leads to removal and replacement of the child. [FN84]

The instability that is inherent in the current foster care system has a remarkable effect on the children who remain stuck in the foster care drift. [FN85] Without stability, young children be come unable to form healthy bonds or feel good about their futures. [FN86] Child psychologists deem permanency and continuity essential for a child's healthy, normal development. [FN87] Without *777 them, a child is unable to form attachment bonds or "ties that bind;" [FN88] the child may experience delays in his adaptation to surroundings or setbacks in his emotional development. [FN89] Bouncing a child from foster home to foster home rips him away from his community and school, which can create great emotional trauma. [FN90] These children are crying out for a stable home with a

caring family. [FN91]

"One of the prime weaknesses of our existing foster care system is that, once a child enters the system and remains in it for even a few months, the child is likely to become 'lost' in the system." [FN92] "Yearly judicial reviews of the child's placement too often become perfunctory exercises with little or no focus upon the difficult question of what the child's future placement should be." [FN93] A significant disincentive exists for taking the risk of placing a child back home with his natural parent unless "you're damn sure everything will be OK." [FN94] No agency will fire a social worker for allowing a child to remain in foster care too long. [FN95] Thus, our existing "temporary" foster care system is a permanent, yet glaringly inadequate, solution for too many innocent children. [FN96]

*778 2. Termination of Parental Rights

Social service agencies may commence permanent termination proceedings after a child is removed from his natural parent's home. [FN97] All fifty states have statutes enabling social service agencies to terminate parental rights in cases of abuse, abandonment or neglect. [FN98] Terminating a parent's right to a child severs the legal relationships between the child and the natural parents. [FN99]

Generally, in the initial removal proceedings the court must first determine by a fair preponderance of the evidence, [FN100] or by clear and convincing evidence that the parents have permanently neglected the child. [FN101] Second, the court must find that the supervising state agency made "diligent efforts to encourage and strengthen the parental relationship" and was unsuccessful at such attempts. [FN102] Following this fact-finding hearing, the agency holds a dispositional hearing to determine what subsequent course of action is not only available, but is also in the best interests of the child. [FN103] Thus, the "paramount concern in these proceedings *779 is the child's best interests." [FN104]

The theory justifying the state's right to intervene is that when parents fail to provide their children with adequate care, "the state has a right, indeed a duty, to protect children." [FN105] The U.S. Supreme Court recognizes the state's interest in protecting its children. [FN106] Since the termination of parental rights is a dramatic and intrusive state action, [FN107] state intervention on behalf of a child must be predicated by a compelling state interest. [FN108] The more significant the harm, the greater the state interest in combating it. [FN109] The main issue is, however, what type of con duct on behalf of the drug addicted mother will invoke a compel ling state interest that warrants intervention. [FN110]

In a termination proceeding, the presiding judge is committed to choosing an alternative that maximizes the best interests of the child. [FN111] This "best interests of the child" standard, however, is a general standard that is inherently indeterminate. [FN112] Since an indeterminate standard can render the outcome of litigation difficult to predict, it can ironically encourage more litigation than a standard that makes the outcome more predictable. [FN113]

Moreover, an indeterminate standard in child custody cases raises a number of questions related to fairness. [FN114] Broad, person *780 orientatedd standards are unfair because the mother may not have the opportunity to conform her conduct to the norm subsequently used by a particular judge. [FN115] Most importantly, the in determinate termination standards violate the fundamental precept that like cases should be decided alike. [FN116] The use of the indeterminate "best interests of the child" standard implies that judges may decide cases on the basis of unarticulated, unconscious predictions and preferences. [FN117] There is a substantial risk that judges will base child custody cases on values not widely shared among other judges or society. [FN118] Thus, "(i)n the end, a judge is the only person a child in peril has to count on. If a judge's humanity fails, who will hear the child's cry?" [FN119]

An excellent illustration of the unfair and inconsistent decisions that can result from the use of an indeterminate standard is a study involving three child welfare professionals. [FN120] Each professional was independently given

the actual files of ninety-four children from fifty families. [FN121] The task was to analyze the files and decide whether the state should remove the children from parental custody and place them in foster care, or whether the state should provide services in the home. [FN122] The three child welfare professionals agreed in less than one-half of ninety-four cases. [FN123] More importantly, when the three professionals agreed on a decision, they did not identify the same determinative factors. [FN124] This study demonstrates how the use of an indeterminate standard results in inconsistent decisions of what is in the best interest of a child. [FN125]

This type of inconsistent decisionmaking for a child's future *781 goes beyond hypothetical studies. For instance, one situation in which the use of an indeterminate standard gravely affected a child's life was the custody battle over a child named Ashley K. [FN126] Ashley was born one month premature and addicted to heroin. [FN127] Ashley's mother and father were both drug addicts who were not married but were living together. [FN128] Ashley's mother also had a history of prostitution, even while she was pregnant with Ashley. [FN129] To make matters worse, before Ashley's birth, Ashley's parents had an open case with the DCFS regarding the neglect of Ashley's brother and sister. [FN130] Additionally, Ashley's mother had a criminal conviction for neglecting her older daughter when she was just fourteen months old. [FN131] After Ashley's birth, the circuit court found that Ashley was a neglected minor and ordered that DCFS take temporary custody of her. [FN132]

Ashley remained in the hospital for approximately one and one half months following her birth because of her drug withdraw al; during that time, Ashley's mother did not visit her. [FN133] When the hospital finally discharged the baby, the state placed Ashley in the foster home of Joseph and Marjorie Procopio. [FN134] During the first five months, baby Ashley suffered from tremors, fever, severe diarrhea and long periods of inconsolable crying. [FN135]

During the first sixteen months of Ashley's life, her biological mother visited her three times and her biological father visited her twice. [FN136] After Ashley's birth, not only was her biological mother arrested for prostitution, possession of stolen property and *782 forgery, but she also continued to use heroin. [FN137] Despite Ashley's parents' criminal conduct, DCFS continued to work towards the goal of returning Ashley to her biological parents. [FN138] Eventually, Ashley's mother entered an outpatient methadone maintenance program; in essence, this program protects the addict so the addict does not commit crimes in order to maintain the addiction. [FN139] DCFS considered this a step forward and did not deviate from its goal of returning Ashley to her biological parents. [FN140]

When Ashley was three years old, Ashley's behavioral and emotional problems concerned the Procopios; they related these problems during the visitations by Ashley's mother and father. [FN141] Subsequently, the Procopios admitted her to an in-patient program at Mount Sinai hospital for a psychological evaluation. [FN142] Mount Sinai reported that the state should return Ashley to her foster parents and implement a permanency plan so that Ashley could be adopted by the Procopios. [FN143] DCFS ignored the recommendations and the monthly visits of Ashley's natural parents continued. [FN144]

When Ashley was five years old, her biological parents petitioned the circuit court to vacate the guardianship order to the DCFS. [FN145] During this hearing, the court reported that her biological mother was drug free. [FN146] A board-certified psychiatrist, however, concluded that it was not in Ashley's best interest to separate her from the foster family she regarded as her real family. [FN147] Despite the psychiatrist's recommendation, the circuit *783 court directed social services to develop a plan to change the supervised visits of the biological parents to unsupervised visits so that reunification could eventually take place. [FN148]

After the circuit court's order, DCFS removed Ashley from the Procopio home and placed her in a shelter as an intermediate step before placing her with her natural parents. [FN149] The shelter forbade the Procopios from calling or visiting Ashley; the shelter considered this a hindrance to the development of the relationship between Ashley and her biological parents. [FN150] Eventually, the circuit court vacated its original order appointing the DCFS Ashley's guardian and entered a dispositional order transferring custody of Ashley to her natural parents. [FN151] By this time, Ashley was five years and four months old and had never lived with her biological parents. [FN152] Additionally, the circuit court ordered that the Procopios refrain from any contact with Ashley that was

not approved by a therapist. [FN153]

The Appellate Court of Illinois, in hearing the appeal from the circuit court, failed to see how the facts taken as a whole could possibly be construed to favor the transfer of Ashley from the custody of the Procopios to her biological parents. [FN154] The Appellate Court stated that the circuit court was wrong: "the facts leave no doubt that it was not in the best interest of Ashley to transfer custody to her biological mother and father." [FN155] Additionally, the Appellate Court disagreed with the determinative factors that the circuit court used in deciding where to place Ashley. The fact that the biological parents stopped using drugs or finally showed an interest in their five year old child was not the determinative criteria to decide the best interest of Ashley. [FN156] Thus, the court remanded the case for a new hearing on the biological *784 parent's petition for custody of Ashley. [FN157]

As demonstrated by the tragic story of Ashley K., [FN158] the "best interests of the child" standard in termination proceedings is vague at best. [FN159] The Appellate Court's sharp disagreement with the lower court's decision demonstrates how an intermediate standard results in inconsistent decisions. Given the enormity of the interests at issue and the finality of the court's decision, [FN160] an ambiguous standard for termination of parental rights does not adequately address the situation or protect the children. [FN161] Foster *785 care placement and termination proceedings are not effectively remedying the problem of drug use among pregnant women; therefore, prosecutors have resorted to criminally prosecuting these mothers.

III. The Criminal Prosecution Of Drug-Abusing Mothers

"Two of the great problems of our democratic society . . . (are) drug use and parents who apparently show no responsibility for their children." [FN162] A judge in an Illinois trial court characterized these types of irresponsible mothers as "time bombs." [FN163] This Part examines the debate among state courts of whether criminal liability should be imposed on pregnant women using drugs. This Part also examines the possible repercussions that may occur from imposing criminal liability on a crack-addicted mother.

A. The Criminal Prosecution of Drug-Abusing Mothers Under State Drug Trafficking Laws

Prosecutors nationwide are fed up with pregnant mothers using cocaine and escaping punishment. [FN164] In a crusade to bring about justice, they have tried to criminally prosecute women for *786 giving birth to children who test positive for drugs. [FN165] Prosecu tors have attempted to charge these mothers with delivering drugs to a minor via the umbilical cord. [FN166] Delivering drugs to a minor is a felony drug charge carrying a possible jail sentence of thirty years. [FN167]

The first case that brought nationwide attention to the issue arose in Florida in 1989. [FN168] Jennifer Johnson admitted to the baby's pediatrician that she used cocaine the night before she delivered her child. [FN169] She was indicted and convicted of two counts of delivering a controlled substance to her minor child in violation of Florida's drug delivery statute. [FN170] The lower court found that Johnson "delivered" cocaine to her two children "via blood flowing through the umbilical cords in the sixty to ninety second period (after birth) but before the cords were severed." [FN171]

On appeal, the Florida Appellate Court upheld the decision. [FN172] The Florida Supreme Court, however, eventually reversed *787 the trial court's and Appellate Court's decisions. [FN173] The Florida Supreme Court reasoned that it was absurd to apply the delivery-of-a-drug statute to this scenario. [FN174] The court held that the Florida Legislature did not intend the Florida Drug Delivery Statute to encompass the delivery of an illegal drug from the womb to the placenta to the umbilical cord and to the newborn after a child's birth. [FN175]

Prosecutors' attempts to hold pregnant drug addicts criminally liable include charging women under controlled substance statutes, [FN176] pure use statutes [FN177] and involuntary manslaughter statutes. [FN178] Some state prosecutors have successfully obtained convictions at the trial level; however, not one state supreme court has upheld such a conviction. [FN179] In the most recent case in Illinois, *788 the Kane County State's Attorney Officedecided to pursue felony drug-possession charges against three women who delivered cocaine-addicted children. [FN180] These cases may be the first time in Illinois that prosecutors charge a mother with cocaine possession while relying on the baby's blood for evidence. [FN181] The chief of the Kane County Felony Division, John A. Barsanti, admitted that he did not find any case law in Illinois related to this type of prosecution. [FN182]

At this time, no state law specifically holds a mother criminally liable for giving birth to a drug-addicted infant. [FN183] Applying state drug trafficking statutes to the passage of blood between a woman and a fetus as a delivery of a drug is extremely problematic. [FN184] Such an interpretation of the statute goes beyond the in tent of the state legislatures in creating those laws. [FN185] Not only *789 are there problems with this type of statutory interpretation of drug trafficking statutes, but there are also inherent problems with imposing any criminal liability on pregnant drug users.

B. The Inherent Problems of Imposing Criminal Liability On Mothers Who Use Drugs During Pregnancy

Opponents attack the criminal prosecution of crack mothers on the grounds that the criminalization infringes on the woman's right to Equal Protection under the Fourteenth Amendment, [FN186] the ban on punishing status under the Eighth Amendment [FN187] and the right to privacy as interpreted under the liberty guarantee of the Fourteenth Amendment. [FN188] Despite these arguments against the imposition of criminal liability on crack-mothers, criminal penalties for pregnant drug-abusers have widespread public support. [FN189] In a survey of fifteen states, seventy-one percent of *790 1500 people polled favored prosecuting women whose use of illegal drugs injured their unborn child. [FN190] After all:
If you raised your child in (a) wilderness and the child's malfunctions punished no one but yourselves, it would be none of their damn business. But if your child is to live with us, be educated by us, suffered by us, add to the crowd of us, we should have a say. [FN191]

Criminalization, however, may provoke the mother to further harm the person the law aims to protect by avoiding prenatal or postnatal care. [FN192] Health care providers are concerned that if women fear that they will be criminally charged for their drug use during pregnancy, these mothers may actually avoid medical care in order to avoid detection for their substance abuse. [FN193] Conse quently, the absence of prenatal and postnatal medical care places drug abusing mothers and their helpless children at even greater risk. [FN194]

Furthermore, crack cocaine is considered one of the most powerful reinforcers in the world, "almost analogous to breathing." [FN195] For addicts, crack "is almost as compelling as breathing" and even "more compelling than the need for sleep or food." [FN196] Although a mother addicted to crack most likely recognizes the potential harm she can cause her fetus, she is unable tocontrol her addiction. [FN197] As long as a mother lacks the power to control and ensure a healthy pregnancy, postnatal sanctions will neither affect her conduct nor protect the child's health. [FN198] Consequently, criminal sanctions may not be an effective deterrent because a drug-abusing mother is not a reality- based individual; [FN199] she is *791 controlled by her addiction and, thus, unable to do what she knows is best for herself and her child. [FN200] The goal of the state is to protect and ensure healthy babies who are not drug- dependent; however, criminal sanctions alone are unlikely to accomplish that goal. [FN201] Punishing a crack mother by ordering her to serve time in jail subjects her baby to the punishment of temporary foster care. [FN202] The overreaching principle is that if the state aims to reach and protect the children, it must first reach the mothers. [FN203]

IV. Legislative and Judicial Response to Drug Using Mothers: A Change in

Policy

Ideally, the most important and effective method of dealing with cocaine use by pregnant women is prevention. [FN204] Our history of success, however, in prohibiting the use of illegal substances does not "inspire the hope that preventing cocaine use will occur quickly." [FN205] For example, a hospital in South Carolina attempted to educate women about the damage they caused to their children by taking cocaine while pregnant. [FN206] Unfortunately, the hospital workers did not convince many of the drug-addicted, pregnant women to enter a drug treatment program. Most of the women did not even return for any type of prenatal care. [FN207] Despite the offer *792 of free drug treatment and free prenatal care, few women voluntarily participated in the program. [FN208] South Carolina's drug rehabilitation specialists asserted that "unless you have sanctions in place, unless you understand the basic irresponsibility of these drug-addicted women, it won't work." [FN209]

Thus, this Part proposes a change in state laws to effectively protect the best interests of a drug exposed child. This Part first discusses programs that successfully protect the children. This Part then proposes an ideal program that protects the health of the child, while also preserving the integrity of the family unit.

A. A Model Solution: South Carolina's Crack Prevention Program

The state must force crack-addicted mothers to realize their responsibility to seek treatment and to protect their children. [FN210] After all, if a mother injected cocaine directly into the tiny arm of her newborn baby, causing permanent brain damage or death, that mother would certainly be arrested and prosecuted to the fullest extent allowed by law. [FN211]

Several years ago, Charleston's Medical University of South Carolina (MUSC) effectively addressed the problem of cocaine abuse during pregnancy. [FN212] Accordingly, the MUSC and the of fice of the circuit solicitor in South Carolina presented all pregnant mothers who tested positive for cocaine use with a choice: the women could either seek drug treatment or face arrest and possible jail time. [FN213] The results of this "crack-baby" prevention program clearly demonstrates that it was a success. [FN214] Prior to the institution of this program, approximately twenty-four pregnant mothers a month tested positive for cocaine at the hospital. [FN215] Almost none of these women were willing to seek help *793 voluntarily. [FN216] After the implementation of the tough amnesty program in 1989, the number of mothers testing positive for cocaine decreased to five or six a month. [FN217]

The basis of the program was "not only a carrot, but a real and very firm stick." [FN218] The cocaine-baby program brought personnel from various groups and agencies to the table, including social workers, Charleston County substance abuse and drug- rehabilitation specialists, law-enforcement officials, hospital officials and prosecutors from the office of the circuit solicitor. [FN219] Whenever a pregnant mother tested positive for drugs, the hospital staff counseled the woman about the consequences of drug abuse during pregnancy. [FN220] In addition, the solicitor's office presented the mother with a letter informing her that she faced ar rest and prosecution if she refused drug treatment. [FN221] The solicitor's office also promised to drop all charges against the woman if she successfully completed a drug-treatment pro gram. [FN222] Most of the pregnant women who tested positive for crack cocaine agreed to enter the drug program. Those women who refused the treatment were arrested, but later agreed to enter the program once they saw that the hospital was serious. [FN223]

Politically correct resolutions by the American Medical Association and the American Pediatrics Association labeled the pro gram as punitive and unwise. [FN224] Subsequently, the Clinton Administration, *794 misguided by its notion that a woman's privacy rights are more fundamental then a mother's most basic responsibility to her own child, forced the end of a program that was clearly saving lives. [FN225] Despite a report conducted by the Office of National Drug Control Policy in 1992 that the "criminal justice system can steer offenders toward drug treatment as a condition for deferred prosecution," the Clinton Administration chose to ignore the practical solutions the program achieved. [FN226]

The cocaine prevention program was neither designed as a punitive measure nor as a method to put people in jail. [FN227] These types of programs are not designed to scare away crack-addicted mothers, but rather to instill in them a sense of responsibility to seek drug treatment. [FN228] Ultimately, these crack prevention pro grams are a major "humanitarian effort to save lives through tough, decisive action under urgent circumstances." [FN229]

B. Proposed Legislative and Judicial Change

The sole purpose of any effort to combat prenatal drug use should be to protect the child and to serve the child's best interests. [FN230] A crack- addicted mother does not have any right to take illegal drugs; thus, the protection and best interests of the child must be the state's top priority. [FN231] The state has a responsibility to uphold the right of children to be born drug-free and to hold accountable those who break the law. [FN232]

This Note proposes that state legislatures adopt a revised version of the crack prevention program instituted by the Medical University of South Carolina. The mission of the state program should be to provide a safe home for the children with their bio logical family by requiring aggressive treatment and *795 rehabilitation. [FN233]

Under such a revised crack prevention program, a woman who is pregnant and found using illegal drugs or a woman who gives birth to an infant who tests positive for drugs would be given an option to either successfully complete a rehabilitation program or to lose her parental rights. In either situation, public health and child protection teams should conduct joint interventions. [FN234] Both teams would set forth a written treatment plan for the mother and child, including the amount of time she has to complete such a plan. [FN235]

It is crucial that the intervention plan differentiate between these developmental impairments caused by prenatal cocaine exposure and those that are the effects of inadequate prenatal care. [FN236] The public health nurse would assess the drug dependency of the mother and prescribe appropriate treatment needed to restore her to health. [FN237] Services, such as drug treatment, health care and family support assistance, would be mandatory. [FN238] Also, a child protection worker would closely monitor the child to help ensure the child's safety from further abuse. [FN239] For the infant, such services would include adequate nutrition, health care and early developmental intervention programs. [FN240]

The coordination of the required child services and drug rehabilitation is also important. [FN241] Keeping multiple appointments in different sites is difficult for mothers with infants, especially mothers with a history of using drugs. [FN242] Thus, providing pediatric health care, drug treatment, child development and family planning in one location with one appointment system would help facilitate a mother's compliance with the system. [FN243] Home visits by the state's social service agency are also important. [FN244] Home *796 visits give social workers the opportunity to meet with the family as their advocates rather than adversaries, sharing and creating mutual goals for the child's nurture and development. [FN245]

However, if the mother failed to remedy the conditions set forth in the treatment plan, the parent's failure would sustain a termination action. [FN246] Initially, the intervention plan will pro vide the mother with a period of time to remedy the problem; however, the plan will not allow years of effort. [FN247] Whereas one or two years may have been the norm to wait before termination of parental rights, many states are increasingly adopting a shorter time period of three to six months. [FN248] Thus, the treatment plan would require that a mother successfully complete her rehabilitation in a strict, minimal period of time, or otherwise face a termination action filed by the state. [FN249]

This program is a "one chance" opportunity. In other words, the mother is given the option to comply with the intervention program or immediately lose her parental rights. [FN250] If she agreed to the intervention program but failed to successfully complete it in the limited time estimated in her plan, the state would terminate the mother's parental rights. There would not be another chance for her to complete the program. It is one strike and you're out!

This type of program seeks to protect the best interests of the child, keeping the child in his own home with his biological parents. [FN251] It works at much greater speed than the current system, *797 while being more sensitive to a child's need for stability and proper care. [FN252] By allowing recovering addicts to care for their in infants at home will not leave open the risk of abuse and neglect because the state will continually monitor the mothers and infants; if the city does find neglect or abuse, the state has the re course to immediately file a petition to terminate a parent's rights. [FN253] This type of program will give children the opportunity to stay with their biological parents, thus giving these parents an incentive to stop using cocaine and to commit to treatment. [FN254] This program is not designed to scare mothers away from seeking prenatal or postnatal care; it simply encourages a mother to take responsibility for the child she brought into this world. [FN255]

Conclusion

State courts and legislatures can never ensure that an unborn child will not be exposed to drugs. [FN256] This type of protection can only come from mothers who take responsibility for the lives of their children. [FN257] Currently, the government raises these drug-addicted children. [FN258] It is time, however, for the government to squarely place this responsibility on the parent's shoulders where it belongs. "(I)t takes more to being a parent than being one of the sexual partners to the physiological formation of a child." [FN259] If the parent does not want that responsibility or cannot handle it, why should the child suffer? Cocaine-addicted babies were once abused by their own mother; now it is time to *798 stop the system from abusing them, too.

[FN1]. This hypothetical example illustrates the typical behavior patterns and complications a drug addicted infant experiences at birth.

[FN2]. Karen Dukess & Karl Vick, Cocaine's Most Innocent Victims, St. Petersburg Times, Sept. 10, 1989, at 1A.

[FN3]. Id.

[FN4]. Id.

[FN5]. Id.

[FN6]. Id.

[FN7]. Id.

[FN8]. Id.

[FN9]. Maureen C. Murtaugh & Susan A. Capra, Cocaine Babies: Meeting the Challenge, 80 Ill. B.J. 348, 354 (1992).

[FN10]. Anastasia Toufexis, Innocent Victims: Damaged by the Drugs Their Mothers Took, Crack Kids Will Face

Social and Educational Hurdles and Must Count on Society's Compassion, Time, May 13, 1991, at 56. The number of women giving birth to crack- addicted children still continues to increase in numbers. James Kimberly, Three Women Who Bore Babies Addicted To Cocaine Charged, Daily Herald, Dec. 31, 1995, S 1, at 4. For instance, the state of Illinois saw the number of drug-addicted infants increase from 1415 infants in 1991 to 1847 infants in 1994. Id. See also Kathleen B. DeBettencourt, The Wisdom of Solomon: Cutting the Cord That Harms; Children and Crack Exposure, Children Today, July 1990, at 17 (quoting Children in Crisis: Young Victims of the Drug Epidemic, Oakland Trib., May 7, 1989) (describing a routine drug bust in Oakland, California in 1989 where police "found a crack mother passed out on her bed, with her seven-month-old baby sitting in a pool of vomit, chewing on cigarettes. A glass crack pipe was nestled between mother and child.").

[FN11]. Jessie Harsham et al., Growth Patterns Of Infants Exposed To Cocaine And Other Drugs In Utero, 94 J. Am. Dietetic Ass'n 999, 1004 (1994).

[FN12]. Steven Brill, Should We Give Up?, Am. Law., Mar. 1990, at 3. See also Committee on Substance Abuse, Drug-Exposed Infants, 96 Am. Acad. Pediatrics 364, 369 (1995) (explaining that recent state surveys show eight to twelve percent of women delivering their children in hospitals used illegal drugs at sometime during their pregnancy, including moments up to delivery).

[FN13]. Toufexis, supra note 10, at 56. Some people often brand this crack addicted generation as the "children of the damned" or the "biological underclass." Id. How ever, many members of society not only pity these innocent victims of society's ills, but also pity the reality of the odds that are against them at home, at school and on the playground. Id. Also, members of society fear that these children will grow into unmanageable groups of disturbed adolescents, thereby becoming a lost generation. Id.

[FN14]. Committee on Substance Abuse, supra note 12, at 364. The peak age range for using illicit drugs is 18 to 34 years, the prime child-bearing years. Harsham et al., supra note 11, at 999. See, e.g., Richard Lacayo, Do the Unborn Have Rights?; The Law is Looking Into the Womb. And Expectant Mothers Who Drink or Use Drugs may be Held Liable for Damage to Their Fetuses, Time, Oct. 1, 1990, at 22 (demonstrating a specific instance where a professional woman attorney, addicted to cocaine, got pregnant and gave birth to a baby girl who tested positive for drugs).

[FN15]. Toufexis, supra note 10, at 56.

[FN16]. Id. Middle to upper class white mothers usually deliver their babies in private hospitals which rarely question the mother about drug use and rarely screen the infants for drugs. Id.

[FN17]. Id.

[FN18]. Committee on Substance Abuse, supra note 12, at 364.

[FN19]. Dukess & Vick, supra note 2, at 1A.

[FN20]. Id. The head of a fetus grows as the brain becomes larger. Id. Since oxygen is limited to the fetus during

vital brain development, the unborn's brain does not grow to full size. Id. See also Toufexis, supra note 10, at 56. The circumference of a drug-exposed child's head is often smaller than a normal, healthy child; frequently, the smaller sized head is a trait associated with a low IQ score. Id.

[FN21]. Committee on Substance Abuse, supra note 12, at 364. See also DeBettencourt, supra note 10, at 17 (explaining that babies exposed to cocaine face an increasing rate of infant mortality resulting from premature birth or low birth weight). Additionally, these drug-exposed infants are at a higher for Sudden Infant Death Syndrome (SIDS). Id.

[FN22]. Harsham et al., supra note 11, at 999. An irritable infant uses more energy. Id. Researchers have found that the use of more energy by cocaine babies causes decreased nutrient absorption. Id. Additionally, these irritable babies may get less food because they are very difficult to feed. Id.

[FN23]. Committee on Substance Abuse, supra note 12, at 364.

[FN24]. Victoria J. Swenson & Cheryl Crabbe, Pregnant Substance Abusers: A Problem That Won't Go Away, 25 St. Mary's L.J. 623, 627 (1994). The irritability and tremors are symptoms of neurological damage, not drug withdrawal. Dukess & Vick, supra note 2, at 1A.

[FN25]. Toufexis, supra note 10, at 56; see also H. Naci Mocan & Kudret Topyan, Illicit Drug Use and Health: Analysis and Projections of New York City Birth Out comes Using a Kalman Filter Model, 62 S. Econ. J. 164, 164 (1995) (stating that cocaine-exposed newborns commonly suffer from intrauterine growth retardation, low birth weight and pre-term delivery more than unexposed infants).

[FN26]. Swenson & Crabbe, supra note 24, at 627.

[FN27]. DeBettencourt, supra note 10, at 17.

[FN28]. Dukess & Vick, supra note 2, at 1A.

[FN29]. Committee on Substance Abuse, supra note 12, at 364. Drug exposed toddlers exhibited lower developmental scores and deficits in the context of free play than toddlers from similar backgrounds who were not exposed to drugs. Id. Prenatal drug exposure was instrumental in the lower developmental outcome at two years of age and lower cognitive ability at three years of age. Id.

[FN30]. Toufexis, supra note 10, at 56. Some children are passive and cry often and some children are so aggressive that they have to be restrained. Id. See also Barbara J. Howard & Karen J. O'Donnell, What is important about a study of within- group differences of "cocaine babies?", 149 Archives of Pediatrics & Adolescent Med. 663, 663 (1995) (explaining that children exposed to drugs have been de scribed by the lay press as "without human emotions of empathy," "so hyperactive as to be unmanageable in the regular classroom" and "doomed to be sociopaths.").

[FN31]. Linda C. Mayes et al., Information Processing and Development Assessments in Three-Month-Old Infants Exposed Prenatally to Cocaine, Pediatrics, Apr. 1995, at 539. See also Toufexis, supra note 10, at 56. Toufexis describes a deaf three year old named Felicia. Id. Doctors are not certain how much she can see. Id. She functions at the level of a four month old and, like a rag doll, she cannot sit or stand by herself. Id. Felicia's foster mother seeks to put her in a special school soon, hoping that Felicia will learn to feed herself. Id.

[FN32]. Toufexis, supra note 10, at 56.

[FN33]. Howard & O'Donnell, supra note 30, at 666. Stereotypes that portray drug- exposed infants as children destined for doom can be a self-fulfilling prophecy. Id.

[FN34]. Toufexis, supra note 10, at 56.

[FN35]. Id. Slavin Special Education Center in Los Angeles conducted a three year pilot program involving 50 drug exposed children, ranging from three to five years of age. Id. The program involved small classes with eight pupils to one teacher, fixed seat assignments and rigid routines. Id. The classroom environment was protected from loud noises or disturbing stimulation. Id.

[FN36]. Id.

[FN37]. Tanya Kne et al., A program to address the special needs of drug- exposed children, 64 J. Sch. Health, 251, 251 (1994). The program was an outgrowth of the 1989 Parent-Child Intervention Program (PCIP). Id. It was designed for the Ravenswood City School District in East Palo Alto, California, to address the needs of children in grades K-3 who were exposed to illicit drugs, such as crack cocaine. Id. at 252. The Learning Center designed a simple atmosphere for the children and encouraged positive and predictable support. Id. Results from this project and similar interventions that compare the neurological development of children not exposed to drugs and these special at- risk children do not show any significant difference in this area. Id. at 253. Thus, remedial education is not required but special attention and early intervention is a must. Id.

[FN38]. Id. Members of the program felt that if this boy had not been part of an intervention program, he was likely to have "remained in his hooded cocoon throughout his elementary years." Id.

[FN39]. Department of Social Services ex rel. Mark S. v. Felicia B., 144 Misc. 2d 169, 171 (N.Y. Fam. Ct. 1989) (citing Woods v. Lancet, 102 N.E.2d 691 (N.Y. 1951)).

[FN40]. Santosky v. Kramer, 455 U.S. 745, 769 (1982) (Rehnquist, J., dissenting).

[FN41]. See infra notes 42-43 and accompanying text for a discussion of state intervention. This Note only examines the major means of intervention by the state, namely civil liability under child abuse and neglect statutes and criminal prosecution under drug trafficking statutes. However, these are not the only methods of intervention. Swenson & Crabbe, supra note 24, at 635. One method is preventative incarceration of a pregnant mother using drugs. Id. Specifically, a pregnant drug user is brought before a state judge on other charges, such as theft or prostitution. Id. The judge, compelled to protect the fetus from further exposure to drugs, jails the mother on

charges unrelated to the drug use -- charges that most likely either have been dismissed or resulted in probation. Id. Another method was implemented by the Honorable Howard R. Broadman, a judge in California. Stephanie B. Goldberg, No Baby, No Jail, 78 A.B.A. J. 90, 90 (1992). Although the decision was ultimately overturned on other grounds, Judge Broadman allowed a child abuser to choose Noraplant, a method of birth control, as part of her sentence. Id. This woman already had five children, none of whom were in her custody; the judge feared that if she became pregnant again, she could give birth to a cocaine addicted baby. Id. These methods of intervention are criticized because they are a "quick fix" for drug addiction and infringe on a woman's constitutional rights to liberty and privacy. Id.

[FN42]. See 705 ILCS 405/2-3 (1992) (defining a neglected or abused minor as an infant whose blood or urine contains any amount of a **controlled substance**); Minn. Stat. Ann. S 626.556 (2)(c) (West 1995) (defining "neglect" as including "prenatal exposure to a **controlled substance**"); Nev. Rev. Stat. S 432.330(1)(b) (1991) ("A child is in need of protection" if he is "suffering from congenital drug addiction or the fetal alcohol syndrome, because of the faults or habits of a person responsible for his welfare."); Okla. Stat. tit. 10, S 7001-1.3 4(a)(3) (1995) (defining a **deprived child** as "a child in need of special care and treatment because of his physical or mental condition including a child born in a condition of dependence on a controlled dangerous substance.").

[FN43]. Sandra Anderson Garcia, Drug Addiction and Mother/Child Welfare, 13 J. Leg. Med. 129, 166 (1992). Women who use drugs during their pregnancy or give birth to a drug-addicted baby usually come to the attention of authorities from intake agency reports where the mother sought prenatal or postnatal care and had urine or blood samples screened for drugs. Id.

[FN44]. Murtaugh & Capra, supra note 9, at 349-50.

[FN45]. Id. at 350. When DCFS is notified, the agency then notifies the local law enforcement and the State's Attorney's Office. Id. DCFS is the sole agency responsible for investigating reports of child abuse and neglect in Illinois, except in cases of death, serious injury or sexual abuse of a child. Id. These exceptional situations warrant a law enforcement agency and DCFS to investigate. Id.

[FN46]. Letter from Theresa Wyatt, Assistant to Illinois Governor Jim Edgar, to the author of this Note, Law Review Staff, The John Marshall Law Review (Nov. 6, 1995) (on file with The John Marshall Law Review). The Illinois Department of Children and Family Services (DCFS) conducts a thorough risk assessment when a report indicates an infant is substance-affected. Id. The risk assessment includes an on-site evaluation of the environment in which the child will live, as well as an evaluation of the caretaker and others who will be residing there. Id. If DCFS discovers that the child is in imminent danger, a child welfare case is opened and the infant is removed into temporary protective custody. Id. If the child is not in imminent danger, the child will remain in the home of the natural parent and a case is opened and referred to the child welfare staff for a comprehensive assessment. Id. The child welfare staff refers the parents to a treatment agency licensed by the Illinois Department of Alcoholism and Substance Abuse (DASA) for an assessment of the mother's addiction and possible treatment. Id. The child welfare staff provides the service activities and treatment plan to the family as prescribed by DASA. Id. Illinois Governor Jim Edgar believes that these DCFS procedures are designed to adequately protect the children who are born substance-affected. Id.

[FN47]. Murtaugh & Capra, supra note 9, at 351.

[FN48]. Id.

[FN49]. Id.

[FN50]. 705 ILCS 405/2-14 (1992). "The legislature recognizes that serious delay in the adjudication of abuse, neglect, or dependency cases can cause grave harm to the minor and the family and that it frustrates the best interests of the minor and the effort to establish permanent homes for children in need." Id. This section of the Illinois statute insures that its intent is consistent with the Federal Adoption Assistance and Child Welfare Act of 1980. Id. See The Adoption Assistance and Child Welfare Act, 42 U.S.C. S 675(5)(c) (1988). The Act provides in pertinent part:
(c) with respect to each such child, procedural safeguards will be applied, . . . to ensure each child in foster care under the supervision of the State of a depositional hearing to be held . . . no later than eighteen months after the original placement . . . which shall determine the future status of the child (including . . . whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should . . . be continued in foster care on a permanent or long-term ba sis . . .).
Id. But see In re Ashley K., 571 N.E.2d 905, 919 (Ill. App. Ct. 1991). Ashley K., a baby born addicted to cocaine, did not have a dispositional hearing for the first five years of her life. Id. Obviously, the court did not comply with the Adoption Assis tance and Child Welfare Act. In noting how important timeliness is in cases like these, the court stated:
(i)f there had been a dispositional hearing . . . (18 months after Ashley's placement) and a dispositional ruling within a reasonable time thereafter, a permanent decision would have been made for her future at a time which would have avoided the turmoil and problems she has suffered and may suffer the rest of her life.
Id.

[FN51]. Murtaugh & Capra, supra note 9, at 350. See also Carl E. Schneider, Moral Discourse And The Transformation Of American Family Law, 83 Mich. L. Rev. 1803, 1807 (1985) (explaining that in the past two decades the legal tradition of noninterference in family affairs shaped the development of family law). This principal transfers many moral decisions from the law to the family. Id. The rationale for the traditional preference for parental autonomy is a commitment to diverse lifestyles and the right of parents to raise their children as they think best. Id. at 1816. Family reunification is preferred and legal judgments regarding the value of child-rearing patterns are discouraged so long as the child is afforded the best opportunity to fulfill his potential in society. Id.

[FN52]. 705 ILCS 405/2-14 (1992). See also supra note 46 (discussing the overall Illinois risk assessment evaluation).

[FN53]. Murtaugh & Capra, supra note 9, at 350.

[FN54]. Id.

[FN55]. Id.

[FN56]. Garcia, supra note 43, at 165.

[FN57]. Id.

[FN58]. See, e.g., Janet L. Dolgin, The Law's Response to Parental Alcohol and "Crack" Abuse, 56 Brook. L. Rev.

1213, 1254 (1991) (stating that the rights of the parents are contrasted with the welfare of the child, making the mother and child adversaries). For example, in In re Ashley, the court stated:
I agree Ashley has rights. I agree that what the best interest of Ashley is, must prevail. But, I also believe that the parents have rights. And that the parent's rights should interplay in this decision. And somewhere, somehow, we have to try to strike a balance between the best interest of the minor and indeed the parental rights.
571 N.E.2d at 923.

[FN59]. In re Doe, 627 N.E.2d 648, 663 (Ill. App. Ct. 1993) (Tully, J., dissenting). See In re Doe, 638 N.E.2d 181, 182 (Ill. 1994) (stating that the Illinois laws protect natural parents and their rights to their children wholly apart from any consider ation of the child's best interests). If the child's best interests alone were a suffi cient basis to determine child custody, anyone with superior income, intelligence or education could challenge the parents of their right to thoir children. Id.

[FN60]. Ashley K., 571 N.E.2d at 923. The Appellate Court of Illinois flatly rejected the Circuit Court's theory that a parent's interest and a child's best interest should be balanced against each other. Id.

[FN61]. Id. See In Re Violetta B., 568 N.E.2d 1345, 1346 (Ill. App. Ct. 1991) (stating that the child's best interest is superior to a natural parent's right to custody of the child); People ex rel. Edwards v. Livingston, 247 N.E.2d 417, 421 (Ill. 1969) (stating that the child's best interest is the appropriate standard).

[FN62]. Dolgin, supra note 58, at 1254.

[FN63]. See Joseph B. Treaster, Plan Lets Addicted Mothers Take Their Newborns Home, N.Y. Times, Sept. 19, 1991, at A5 (explaining how child welfare officials state that they routinely move drug addicted babies to the foster care system for the child's own protection against risks of abuse and neglect).

[FN64]. Dolgin, supra note 58, at 1214.

[FN65]. Patrick F. Fagan, Why Serious Welfare Reform Must Include Serious Adoption Reform, Heritage Found. Rep., July 1995, at 1. Children enter the foster care system for a variety of reasons, most commonly child abuse or neglect, a parent's physical or mental illness or parental inability to provide child care. Marsha Garri son, Why Terminate Parental Rights?, 35 Stan. L. Rev. 423, 427 (1983). Seventy percent of foster children enter the system because of abuse, neglect or parental conditions, such as drug addiction, incarceration or illness. Conna Craig, What I Need is a Mom, 73 Pol'y Rev. 41, 41 (1995).

[FN66]. Garrison, supra note 65, at 427.

[FN67]. Id. at 423.

[FN68]. Id.

[FN69]. Id.

[FN70]. Id. at 428.

[FN71]. Id.

[FN72]. Id. at 428-29. For instance, an Arizona study revealed that 56% of natural parents were not offered services while their children remained in foster care. Id.

[FN73]. Id. In Iowa, 65% and in Massachusetts, 60% of the natural mothers surveyed did not have any contact with the state agency within six months or more of their child's removal. Id. See also Treaster, supra note 63, at A5 (showing how one mother commented that if social services just removed her son without any further communication she would have kept on "drugging" because she would have no baby). She said getting the chance to keep her child made her go through a drug program. Id.

[FN74]. Garrison, supra note 65, at 428.

[FN75]. Id. at 429.

[FN76]. Craig, supra note 65, at 41.

[FN77]. Id. The youngest children, such as drug-addicted infants, remain in the system longest. Id.

[FN78]. Id. See also Punishing Pregnant Addicts: Debate, Dismay, No Solution, N.Y. Times, Sept. 10, 1989, S 4, at 5 (hereinafter Pregnant Addicts). Eve W. Paul, the director of legal affairs of The Planned Parenthood Federation in New York commented:
We thought we were getting tough when we tried voluntary contracts that required the parents to go into drug treatment, gave the state legal custody or allowed it to monitor the child. But it doesn't work. In a few weeks, the family disappears from the system and the child protection agencies are too overwhelmed to follow through. In a year, the family shows up with another drug-affected baby.
Id.

[FN79]. Craig, supra note 65, at 41. Biological parents are given multiple chances to be a fit parent, while innocent, helpless children are bounced between the state and their natural family. Id.

[FN80]. Id. Most states give biological parents every possible opportunity to prove they are fit. Id. One adoptive family dotes over their two-year-old foster daughter:
(s)he is precious beyond belief, and her parents are being given chance upon chance to clean up their lives, at her expense, as we see it. She is so adoptable by the right family, but the system will keep her under lock and key for years if necessary for her parents' benefit.
Id. See also Fagan, supra note 65, at 1 (stating that laws and policies that are ostensibly predicated on the protection of the children have created barriers that prevent these children from getting the protection they need, a loving and permanent home).

[FN81]. Craig, supra note 65, at 41. For example, "Halie," a two and one half year old girl lived with her biological mother until the day "Halie's" mother tied her to an electric heater and left her there for hours. Id. The baby girl's face, chest and arms were disfigured. Id. After weeks of hospitalization, "Halie" was placed in the foster care system. Id. "Halie" turned 18 years old in foster care because she was never allowed to be adopted; social service agencies coached her natural mother in maintaining her legal rights to the child. Id.

[FN82]. Fagan, supra note 65, at 1. A psychologist specializing in attachment disorders remarks, "(e)very new placement is a disaster. The result is that these kids begin not to trust anyone." Id.

[FN83]. Garrison, supra note 65, at 429.

[FN84]. Id.

[FN85]. See Andrea Neal, Hundreds of Children Still Languish in Limbo in Foster Care System, Indianapolis Star, Aug. 14, 1994, at A1 (asking "(w)hy are we beating them up in 10 or more placements? It's simply unconscionable").

[FN86]. Id.

[FN87]. Jamie D. Manasco, Parent-Child Relationships: The Impetus Behind the Gregory K. Decision, 17 Law & Psychol. Rev. 243, 252 (1993). Children who grow up feeling unwanted in a unstable home can experience "serious scars" which can result in anger, rage, a dysfunctional adulthood or a life filled with violence. Id.

[FN88]. See Prepared Testimony of Carol "Cassie" Statuto Bevan, Ed.D., Before the House Committee on Ways and Means Subcommittee on Human Resources re: Child Welfare Reform, Fed. News Serv., 1995 WL 6621184 (Feb. 3, 1995).

[FN89]. Manasco, supra note 87, at 251-52. Any disruption in the continuity of developing and existing relationships will affect young children; these children will often build up resentment and develop a cold attitude towards everyone. Id.

[FN90]. Bernie Mixon, Foster Care Is Taking Neighborly Approach -- DCFS Joins Hull House In Experiment Aimed At Preserving Family, Chi. Trib., Apr. 25, 1995, at 1. See also Sharon Cohen, Part II: Nobody's Children: Living in Limbo -- And Waiting For a Home, Assoc. Press, 1995 WL 4385574 (Apr. 30, 1995). Tammy, a foster child bounced in the system for six years, comments on the foster system: "You never get comfortable. You're always the outsider. . . . I didn't really ever have no parents. . . . I always said if nobody wants me, that's OK. When you're little, you just want people to love you. Maybe if I had parents, I wouldn't have grown up so fast." Id.

[FN91]. See Cohen, supra note 90. James, 16 years old, lived his entire life in foster care. Id. James commented that, "(a)ll my friends have mothers and fathers. . . . If I could have anything, I'd like to have a family. I think that's the way it should be." Id.

[FN92]. In re Ashley K., 571 N.E.2d 905, 918 (quoting Sen. Allen Cranston in 125 Cong. Rec. S22684).

[FN93]. Id. See also Cohen, supra note 90. James Randall's foster care case was on inactive status, a status one attorney mockingly calls "never- neverland." Id. The courts were required to monitor him regularly, however, they only did so twice in seven years. Id.

[FN94]. Id.

[FN95]. Id.

[FN96]. Ashley K., 571 N.E.2d at 918. See Craig, supra note 65. Drug addicted children placed in the foster system face long term, temporary placements without any significant on-going parental relationship. Id. See also Cohen, supra note 90. The presiding judge of the Marion County, Indiana Juvenile Court commented that "kids don't fall through the cracks . . . We throw them in and grind them down so they're out of sight." Id.

[FN97]. Santosky v. Kramer, 455 U.S. 745, 776 (1982). Permanent termination proceedings are commenced by the filing of a petition in the court which orders the temporary removal. Id. The petition is filed by a state agency or by a foster parent authorized by the court. Id. at 777. Moreover, the petition must allege that the child has been permanently neglected by the parents. Id. at 778.

[FN98]. Manasco, supra note 87, at 246.

[FN99]. Id.

[FN100]. Santosky, 455 U.S. at 751. Only competent, material and relevant evidence will be admitted. Id. at 780.

[FN101]. Id. at 751. The substantive standards vary from state to state. Id. at 769. Fifteen states, the District of Columbia and the Virgin Islands have required "clear and convincing evidence" or its equivalent. Id. South Dakota's Supreme Court requires a "clear preponderance" of the evidence in a dependency proceeding. Id. at 751, n.3. Illinois and New York generally require a preponderance of the evidence, but require clear and convincing evidence to terminate the parental rights for rea sons of mental illness, retardation or severe and repeated child abuse. Id. Two federal courts have held that allegations in evidence in termination proceedings must be proven by clear and convincing evidence. Id.

[FN102]. Id. at 779. The state's first obligation is to reunite the child with his natural parents. Id.

[FN103]. Id. at 780. The court has the option to either dismiss the petition or sus pend judgment on the petition and retain jurisdiction for a period of one year in order to provide further opportunity to reunite the family or terminate the parents' right to custody. Id. Regardless of which avenue the court chooses, its decision is solely based on the record of "material and relevant evidence" introduced at the depositional hearing and not on a presumption of what will promote the best inter ests of the child. Id.

[FN104]. J.L.B. v. State Dep't of Human Resources, 608 So. 2d 1367, 1368 (Ala. Civ. App. 1992).

[FN105]. In re Philip B., 156 Cal. Rptr. 48, 51 (Cal. Ct. App. 1979).

[FN106]. Prince v. Massachusetts, 321 U.S. 158, 167 (1944). The Court reasoned that "the state has a wide range of power for limiting parental freedom and authority in things affecting child welfare." Id.

[FN107]. In re Valerie D., 613 A.2d 748, 752 (Conn. 1992).

[FN108]. Sonja C. Davig, Crack Cocaine Babies: Protecting Society's Innocent Victims, 15 Hamline J. of Pub. L. & Pol'y 281, 296 (1994).

[FN109]. Id. See also In re Stefanel Tyesha C., 556 N.Y.S.2d 280, 286 (N.Y. App. Div. 1990) (stating that the responsibility of the courts is to protect a living child's legal rights and interests in remaining alive and to protect him from physical injury when others have failed).

[FN110]. Garcia, supra note 43, at 129.

[FN111]. Robert H. Mnookin & D. Kelly Weisberg, Child, Family, & State 721 (3d ed. 1995).

[FN112]. Id. "The indeterminacy flows from our inability to predict accurately human behavior and from a lack of social consensus about the values that should inform the decision." Id. at 729. See Santosky v. Kramer, 455 U.S. 745, 769 (1982) (stating that termination proceedings often require the fact-finder to decide issues that are difficult to prove to a degree of certainty); In re A.W., 569 A.2d 168, 169 (D.C. 1990) (showing that the court's expectation is that the case evidence will bring enlightenment of what will be in the best interest of the child).

[FN113]. Mnookin & Weisberg, supra note 111, at 728. A broad child neglect standard giving great discretion to a juvenile court to remove a child from the natural parent may encourage social workers, probation officers and other state agencies to seek intervention in a broader range of cases than might a narrow standard. Id.

[FN114]. Id. More clearly defined and less discretionary standards can minimize the lack of fairness problem. Id.

[FN115]. Id. Broad standards also do not give the party notice and opportunity to address the grounds that the court uses as the basis for the judgment. Id.

[FN116]. Id. Proponents who argue that people differ and no two cases are the same claim that no process is more fair than one decided by a highly individualized, person-orientated standard. Id. However, when such a discretionary standard is applied, the very same case presented to different judges can easily result in different decisions. Id.

[FN117]. Id.

[FN118]. Mnookin & Weisberg, supra note 111, at 728-29. The judge's decision today need not be reconciled with decisions made earlier in similar cases. Id. at 728.

[FN119]. Bob Greene, Who Will Hear the Child's Cry?, Chi. Trib., Aug. 22, 1993, at C1.

[FN120]. Mnookin & Weisberg, supra note 111, at 729. Each child welfare professional had at least five years experience. Id.

[FN121]. Id.

[FN122]. Id.

[FN123]. Id.

[FN124]. Id.

[FN125]. Id. In the current juvenile system, a trial judge has the primary authority to decide what are the child's best interests although it is unclear how her responsibility is affected by social workers, psychologists and psychiatrists. Id.

[FN126]. See In re Ashley K., 571 N.E.2d 905, 909 (Ill. App. Ct. 1991).

[FN127]. Id. at 906.

[FN128]. Id.

[FN129]. Id. Ashley's parents' drug use increased and they had difficulty in supporting their habits. Id. Ashley's father was not working at the time and they were living off of the mother's social security money. Id. The mother confessed that she never stole anything to support their drug habits. Id. However, she did admit that she was a prostitute. Id. She confessed that she prostituted herself enough to get the drugs which she took home and used, often with the father. Id.

[FN130]. Id. at 907. "When Ashley was born, her (parents) had five DCFS reports of inadequate and unsafe housing involving Ashley's . . . sister and brother." Id. One DCFS report revealed that at one time the family was living in a car. Id. Another report revealed that there was no furniture or appliances in the family's apartment, except two mattresses, a dresser and a hot plate. Id.

[FN131]. In re Ashley K., 571 N.E.2d 905, 907 (Ill. App. Ct. 1991).

[FN132]. Id.

[FN133]. Id. Ashley's mother claims that DCFS lied to her and told her that Ashley was in a home, not the hospital. Id.

[FN134]. Id. The "Procopios are an attractive middle class couple who present themselves as intelligent, mature residents of Bridgeview, Illinois." Id. The couple was married in 1982. Id. Mr. Procopio had six grown children from a previous marriage and Mrs. Procopio had one grown daughter. Id.

[FN135]. Id. at 907-08.

[FN136]. In re Ashley K., 571 N.E.2d 905, 908 (Ill. App. Ct. 1991).

[FN137]. Id. Ashley's father was also convicted of forgery. Id.

[FN138]. Id. DCFS's service plan for Ashley continued to be reunification with her biological parents despite the fact that DCFS workers told the Procopios that the biological mother and father would "never make it" and that they would never get into rehabilitation for drug addiction. Id. at 909.

[FN139]. Id. at 909. Methadone maintenance programs may be characterized as a "controlled legal addiction." Id.

[FN140]. Id.

[FN141]. In re Ashley K., 571 N.E.2d 905, 910 (Ill. App. Ct. 1991).

[FN142]. Id. According to a Mount Sinai report of an observed meeting between Ashley and her biological parents:
Ashley broke into tears at the sight of her biological parents and clung to the examiner. She appeared very distressed and her behavior was regressive. For example, she started sucking her thumb and laid on the examiner's lap in a fetal position. After a few questions, Ashley broke into tears and ran for the bed. She was crying and repeatedly stated, "I want my real mommy," referring to her foster mother.
Id.

[FN143]. Id. Although these findings were not contradicted by medical evidence, the DCFS ignored the recommendations. Id.

[FN144]. Id.

[FN145]. Id. at 911.

[FN146]. In re Ashley K., 571 N.E.2d 905, 912 (Ill. App. Ct. 1991).

[FN147]. Id. The doctor had reviewed the case, interviewed Ashley, the foster parents and the biological parents. Id.

[FN148]. Id. at 913. The judge ordered that the petition to vacate the guardianship order and return custody of Ashley to her natural parents should be continued to another date. Id.

[FN149]. Id. at 914.

[FN150]. Id.

[FN151]. In re Ashley K., 571 N.E.2d 905, 915 (Ill. App. Ct. 1991).

[FN152]. Id.

[FN153]. Id. at 916.

[FN154]. Id. at 922. The court found that when the facts were construed in favor of the biological parents, at best they demonstrate that although they have a 10 year history of drug abuse, repeated prostitution, child neglect, child abandonment and a forgery conviction, they stopped using drugs for a 13 month period. Id. The court further held that the drug free period consisting of 13 months is "negligible when (considering the risk of) recidivism for heroin and cocaine addicts and the kind of risk that is involved in putting a child of Ashley's age in the environment that drug addiction breeds." Id.

[FN155]. Id. at 923.

[FN156]. In re Ashley K., 571 N.E.2d 905, 923 (Ill. App. Ct. 1991).

[FN157]. Id. Compare with In re A.W., 569 A.2d 168 (D.C. 1990). In In re A.W., a mother gave birth to a baby suffering from drug withdrawal; consequently, she agreed to commit the child to the Department of Human Services (DHS). Id. at 169. Additionally, she promised to maintain a regular schedule of visits with her baby and complete a drug counseling program. Id. The mother, however, failed the drug program and began to abuse drugs again; subsequently, she was incarcerated. Id. DHS officials recommended the termination of the mother's parental rights. Id. This action by the DHS prompted the mother to assert her desire to be reunited with A.W. Id. Despite the mother's argument that termination was premature because no adoptive parents had been identified for A.W., the District of Columbia's Court of Appeals held there was clear and convincing evidence to support a decision that termination was in the best interests of the child. Id. at 168. Chief Justice Rogers dissented, asserting that the majority made no reference to the significant evidence that the mother requested visitation with her child and

expressed the desire to be reunified with A.W. Id. at 176 (Rogers, C.J., dissenting). Moreover, the dissent argued that this was a premature termination of the mother's parental rights. Id. at 177. Rogers reasoned that A.W. would be subjected to the very circumstances that the court seeks to avoid: "the agony of a rootless child who remains adrift in the foster care system without any permanent familial relationships." Id. Thus, Chief Justice Rogers seriously questioned whether A.W.'s best interests were adequately assessed. Id.

[FN158]. In re Ashley K., 571 N.E.2d at 905. Ultimately, Judge Robert Smierciak ruled that Ashley would remain in her natural parent's home with regular visits with her foster parents. Rob Karwath, Judge Heeds 'Sarah'; Rules for Her Parents, Chi. Trib., Oct. 9, 1991, at C1. In addition, Judge Smierciak imposed intense monitoring of the biological parents to ensure that they were properly raising Ashley. Id. The main impetus for deciding that Ashley should remain with her biological parents was a report from two court appointed psychiatrists. Id. The psychiatrists told Judge Smierciak that uprooting Ashley from a second family would be even more traumatic than her original removal from the Procopios. Id. Judge Smierciak did not view his decision as a victory for the birth parents or a loss for the adoptive parents. Id. According to Judge Smierciak, this was a victory for the little girl and her chance for a start of a normal life. Id.

[FN159]. In re A.W., 569 A.2d at 176 (Rogers, C.J., dissenting).

[FN160]. Id. at 169.

[FN161]. See Schneider, supra note 51, at 1815. Currently, popular opinion favors defining the grounds for intervention narrowly and specifically so that the state is allowed to act only when the child suffers or risks severe physical or mental injury. Id. This approach decreases intervention based on value judgments concerning appropriate child-rearing practices. Id. In light of the seriousness of the court's decision to intervene in a family, intervention should only be allowed where there is a clear-cut decision, openly and deliberately made by responsible political bodies. Id. at 1816. Value judgments should not be decided by the individual opinions of hundreds of nonaccountable decision-makers. Id.

[FN162]. People v. Bedenkop, 625 N.E.2d 123, 130 (Ill. App. Ct. 1993) (Murray, J., concurring).

[FN163]. Id. at 129. The defendant pleaded guilty to possession of a controlled sub stance with intent to deliver and delivery of a controlled substance and was sentenced to two years' probation. Id. at 124. When the defendant failed to "appear and report," a petition to revoke her probation was filed. Id. At the revocation hearing, the court learned that the defendant gave birth to an infant addicted to cocaine. Id. at 125. Additionally, the court learned that the defendant's two other children were also exposed to cocaine in utero. Id. at 128. The judge was outraged and asked the defendant, "(h)ow many more times am I going to allow you to be come pregnant and to have more children damaged by their exposure to cocaine in your womb?" Id. The judge further stated that he did not want to see that woman become pregnant again for fear that she may endanger the life or quality of life of another child. Id. at 129. The judge sentenced the defendant to seven year's imprisonment. Id. at 125. The defendant appealed and the Appellate Court of Illinois reversed and remanded the lower court's decision. Id. at 130. The court reasoned that the defendant was deprived of her due process rights when the lower court broadened the scope of her revocation proceeding without providing her notice; the petition to revoke defendant's probation only referred to her failure to report, not to her drug use while pregnant. Id. at 125.

[FN164]. See Pregnant Addicts, supra note 78, at 5. Eve W. Paul, director of legal affairs at Planned Parenthood Federation in New York commented, "I'm fed up with seeing damaged babies born who have lost the right to make

what they can out of life. And, as the years go by, I don't see that the courts have had any impact." Id. Ms. Paul also believes that society cannot promise that people will have unlimited rights to have a child forever. Id. "We license people to cut hair but we don't have to have any kind of training to have a child. What's more important -- a bad hair cut or a permanently damaged child?" Id.

[FN165]. See, e.g., Johnson v. State, 602 So. 2d 1288 (Fla. 1992); People v. Hardy, 469 N.W.2d 50 (Mich. Ct. App. 1991) (dismissing a felony charge against a mother for delivering cocaine to her fetus through the umbilical cord); People v. Morabito, 580 N.Y.S.2d 843 (N.Y. City Ct. 1992) (dismissing a felony charge of child endanger ment against a mother who smoked crack while pregnant).

[FN166]. Wendy Chavkin, Help, Don't Jail, Addicted Mothers, N.Y Times, July 18, 1989, at A21. See Hardy, 469 N.W.2d at 55 (Reilly, J., concurring). The Michigan Court of Appeals held that cocaine used by pregnant woman and transferred to her baby through the umbilical cord is not the type of conduct that the legislature intended to be prosecuted under the delivery of cocaine statute. Id. The court noted, however, that the court's decision that the mother cannot be charged with de livery of a controlled substance will not interfere with prosecution for the less serious offense of possession of an illegal drug. Id. The court stated that the defendant may properly have been charged with possession of cocaine when she admitted to smoking crack. Id. at 53.

[FN167]. Chavkin, supra note 166, at A21. This is commonly the charge made against drug dealers. Id.

[FN168]. Johnson v. State, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991) rev'd, 602 So. 2d 1288 (Fla. 1992).

[FN169]. Johnson v. State, 602 So. 2d 1288, 1291 (Fla. 1992).

[FN170]. Id. The Florida Statute provides:
It is unlawful for any person 18 years of age or older to deliver any con trolled substance to a person under the age of 18 years, or to use or hire a person under the age of 18 years as an agent or employee in the sale or delivery of such a substance, or to use such person to assist in avoiding detection or apprehension for violation of this chapter. Any person who violates this provision with respect to: (A) A controlled substance . . . commits a felony of the first degree . . .
Fla. Stat. Ann. S 893.13(4) (West 1994).

[FN171]. Johnson, 602 So. 2d at 1290.

[FN172]. Johnson, 578 So. 2d at 420. The court found that the appellant's arguments that the Florida Legislature declined to pass a child abuse statute which forbade Johnson's conduct and as to what pregnant mothers would resort to if they knew they may be charged with this crime were unimpressive. Id. The court simply stated in their two page majority opinion that Johnson violated Florida's delivery statute two times by taking cocaine into her pregnant body and causing the pas sage of that cocaine to her child through the umbilical cord after the birth of the child. Id. Specifically, the court found that Johnson voluntarilyingested cocaine, knowing not only that it would pass to her fetus, but also that the birth was imminent. Id. Thus, Johnson was deemed to know that an infant at birth is a person and a minor, and that delivery of cocaine to a minor is illegal. Id. The court stated that they could "reach no other conclusion logically." Id. In Justice Cobb's concur ring opinion,he argued that if the Florida Legislature wished to exempt the trans mission of cocaine through the umbilical cord from the Florida Drug Delivery Stat ute, it was their prerogative; however, the legislature had not done so. Id. at 421 (Cobb, J.,

concurring). Furthermore, Justice Cobb reasons that the court's function is not to set forth public policy reasons for actions taken or not taken by the legislature, but to apply the law. Id.

[FN173]. Johnson, 602 So. 2d at 1288.

[FN174]. Id. at 1292.

[FN175]. Id. at 1293. The court reasoned that criminal statutes must be strictly, not loosely construed. Id. at 1293. The court noted that the Legislature chose to treat the problem of drug exposed newborns as a public health problem and it expressly rejected imposing criminal sanctions via S 893.13(1)(c)1 of the Florida Drug Delivery Statute. Id. at 1293. In 1987, the Florida Legislature stated that no parent of a drug-addicted infant will be subject to criminal investigation solely on the basis of the child's drug dependency. Id. In justifying this policy, the House stated that its primary goal is to keep families intact. Id.

[FN176]. Shona B. Glink, The Prosecution of Maternal Fetal Abuse: Is This the An swer?, 1991 U. Ill. L. Rev. 533, 544 n.129. Prosecutors in Florida, Illinois, Colora do, South Carolina, Michigan and Indiana attempted to charge women under their controlled substance statutes. Id.

[FN177]. Id. at 551. Pure use statutes, which make it a crime to use drugs, have been passed in only a few states. Id. If this statute were used to prosecute pregnant women using drugs, the mother would be penalized for using an illegal drug, not for harming her fetus. Id. Moreover, using pure use statutes to prosecute drug abusing mothers raises evidentiary problems of proof and most states are reluctant to pass pure use statutes to prosecute drug-addicted mothers. Id.

[FN178]. Id. at 551-52. State prosecutors from Rockford, Illinois in 1989 charged Melanie Green with involuntary manslaughter because her child was born with cocaine in her system and subsequently died. Id. at 552. The grand jury refused to indict Green. Id. They reasoned that the legislature did not intend for the man slaughter statute to impose criminal liability on a pregnant women for the death of her fetus. Id.

[FN179]. Marcy Tench Stovall, Looking for a Solution: In re Valerie D and State Intervention in Prenatal Drug Abuse, 25 Conn. L. Rev. 1265, 1270 (1993). One prosecutor commented that this is a "very minor setback" and that although he is not "sitting on rock-solid legal ground," something needs to be done. Id. at 1271. See also Glink, supra note 176, at n.176. Many prosecutors argue that they bring these suits to awaken the state legislatures for the need to enact legislation "to deal with the growing problem of drug-dependent infants." Id.

[FN180]. Kimberly, supra note 10, at 4. A Kane County grand jury indicted the first women on the felony drug charges in the summer of 1995. Id. The criminal cases against the women, however, are slowly proceeding because two of them have not been arrested for the felony charges. Id.

[FN181]. Id.

[FN182]. Id.

[FN183]. Letter from Theresa Wyatt, supra note 46. See H.R. Res. 2262, 86th Leg., 2d Sess., 1989 Ill. Laws. Illinois has left the issue of criminal liability on cocaine mothers unanswered. Id. For example, Illinois was in the process of amending its Juvenile Act to provide that a neglected minor includes a newborn infant who is physically dependent on a controlled substance. Id. When the amendment was on the floor for debate, Illinois Representatives McCracken and Young made it clear that this provision did not, in any capacity, answer the question whether a mother could be criminally charged if a controlled substance was found in the bloodstream of her infant:
Q: Would (this amendment) have any effect on the mother, in terms of any criminal effects or presumptions . . .
A: No.
Q: . . . Or . . . How . . . in terms of this Amendment in this Bill, is this . . . do you consider this merely a civil procedure to have no effect one way or another or do you consider this to be an alternative procedure, these instances to a criminal procedure?
A: No, no. It has nothing to do with the criminal procedure.
Q: So in terms of whether a mother could still be charged or would not be charged criminally, but would just be subject to being neglected parents, this Bill doesn't try to answer that question in either event?
A: No.
Id.

[FN184]. Margaret Phillips, Comment, Umbilical Cords: The New Drug Connection, 40 Buff. L. Rev. 525, 548 (1992).

[FN185]. Id. at 549. For example, Florida and Michigan legislatures sought to control drug trafficking through their current statutes and did not intend for the statute to be applied to pregnant drug users. Id.

[FN186]. The Fourteenth Amendment states that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, S 1. Thus, any statute discriminating against a class of persons will be scrutinized to determine if it complies with the Fourteenth Amendment. Julia Elizabeth Jones, State Intervention in Pregnancy, 52 La. L. Rev. 1159, 1166 (1992). However, the Equal Protection Clause does not "demand that a statute necessarily apply equally to all persons" or require "things which are different in fact . . . to be treated in law as though they were the same." Rinaldi v. Yeager, 384 U.S. 305, 309 (1966) (quoting Tigner v. Texas, 310 U.S. 141, 147 (1940)). The Court, in recognizing the inherent, fundamental differences between men and women, has upheld statutes which discriminate against a gender. Michael M. v. Superior Court, 450 U.S. 464, 470 (1981) (upholding a statute that held only men liable for statutory rape).

[FN187]. Phillips, supra note 184, at 555. Some critics argue that prosecuting moth ers for delivering drugs to their fetuses is discriminatory treatment against pregnant women. Id. Moreover, critics argue that explicitly criminalizing drug use by pregnant women will subject women to disproportionate punishment because of their biological connection to their fetus. Id. at 554. See also Stovall, supra note 179, at 1274-75. Criminalization of prenatal drug use would impose a burden of state intrusion on pregnant women, a burden not borne by men or non-pregnant women. Id. at 1275. Additionally, criminalizing prenatal drug use is dangerously close to penalizing a woman for her status as an addict. Id. at 1276-77 However, the Supreme Court forbids punishment based on an individual's status as an addict. Id. at 1277.

[FN188]. Phillips, supra note 184, at 552. The Fourteenth Amendment argument is that drug delivery charges violate a mother's fundamental privacy right of procreation and the right to autonomy in reproductive decision making. Id. A violation of a women's fundamental right to privacy is justified if the state has a compelling interest in a viable child that overrides the defendant's privacy right. Id. Those in opposition to criminal prosecution of drug abusing mothers argue that there are less intrusive means for the state to guard its compelling interest, such as education, medical care and drug treatment programs for pregnant women. Id. See infra notes 203-08 and

accompanying text for a discussion of the limited effects of education and prevention programs.

[FN189]. Mark Curriden, Holding Mom Accountable: Roe v. Wade Does Not Prevent Criminal Prosecution of Prenatal Child Abuse, 76 A.B.A. J. 50, 51 (1990).

[FN190]. Id.

[FN191]. Mnookin & Weisberg, supra note 111, at 94.

[FN192]. Schneider, supra note 51, at 1837. The mother who is criminally prosecuted would be able to injure the child, the very person the law intervenes to protect. Id.

[FN193]. Stovall, supra note 179, at 1277. It defies common sense to discourage or drive pregnant women away from prenatal care. Id. at 1278.

[FN194]. Id.

[FN195]. Id. at 1279.

[FN196]. Id.

[FN197]. Note, Rethinking Motherhood: Feminist Theory and State Regulation of Pregnancy, 103 Harv. L. Rev. 1325, 1342 (1990). Maternal substance abuse does not derive from the mother's lack of incentive to protect the fetus, but her lack of control over the necessary conditions to ensure the health of her baby. Id. See also Chavkin, supra note 166, at 21A. The majority of pregnant mothers long to do what's right for their children. Id.

[FN198]. Note, supra note 197, at 1342. See also Chavkin, supra note 166, at 21A. Prenatal drug use will not be solved by policing pregnant women or jailing moth ers. Id. These crack addicted mothers need treatment, not prosecution. Id.

[FN199]. Dr. Ira Chasnoff, Fear Is Not a Deterrent, in Punishing Pregnant Addicts: Debate, Dismay, No Solution, N.Y. Times, Sept. 10, 1989, S 4, at 5. Criminalization is just a short-term, knee-jerk solution that will not accomplish anything in the long run. Id.

[FN200]. Dr. Jan Bays, People Are Talking About Sterilization, in Punishing Pregnant Addicts: Debate, Dismay, No Solution, N.Y. Times, Sept. 10, 1989, S 4, at 5. Drug addicts, who have strong denial mechanisms, often rationalize that they will never be caught. Chasnoff, supra note 199.

[FN201]. Pregnant Addicts, supra note 78, at 5. "Criminalizing is a barbaric approach to deal with someone who is sick." Eve W. Paul, Barbaric Approach to an Illness, in Punishing Pregnant Addicts: Debate, Dismay, No Solution,

N.Y. Times, Sept. 10, 1989, S 4, at 5. This frustrating problem calls for protective action, not punish ment. Pregnant Addicts, supra note 78, at 5.

[FN202]. See supra notes 85-91 and accompanying text for a discussion of the effects of foster care on children.

[FN203]. See In re Valerie D., 613 A.2d 748, 752 (Conn. 1992).

[FN204]. Robert Horowitcz, Perinatal Substance Abuse: A Coordinated Public Health And Child Welfare Response, 19 Children Today 8, 8 (1990). Prevention is the cheapest and easiest remedy to attempt. Id. Prevention methods entail education about the effects of drug use while pregnant. Id. This may reduce the number of drug addicted mothers; however, it will not eliminate the problem. Id. For in stance, recent attempts to educate pregnant women about the effects of taking legal drugs, such as anti-acne drugs, have not halted the use of these drugs by mothers. Id.

[FN205]. Linda C. Mayes et al., The Problem of Prenatal Cocaine Exposure, 267 JAMA 406, 408 (1992).

[FN206]. Charles Molony Condon, Clinton's Cocaine Babies: Why Won't the Administration Let Us Save Our Children, Pol'y Rev., Spring 1995, at 12.

[FN207]. Id.

[FN208]. Id. Many of the women were poor and uneducated and received free coun seling from the hospital. Id.

[FN209]. Id.

[FN210]. Mark Curridan, Crack Addicted Mother Faces Charges, Atlanta J. & Const., June 5, 1991, at D1. See, e.g., Scott Bronstein, The Crack Epidemic; Saving Not One Life -- But Two; Project Prevent: Grady Program Treats Pregnant Women Addicted to Cocaine; Before They Give Birth, Helping Both Mother and Child, Atlanta J. & Const., Nov. 28, 1991, at E1 (telling a series of success stories of pregnant crack mothers and the program that helped them). It is important to note that this program was a voluntary program, not one in which the state mandated treatment.

[FN211]. Condon, supra note 206, at 12.

[FN212]. Id. The MUSC could not continue to watch the birth of crack babies and pay the increasingly high price in dollars and human suffering. Id.

[FN213]. Id.

[FN214]. Id. This was one of the first "crack-baby" prevention programs in the nation. Id.

[FN215]. Id.

[FN216]. Id.

[FN217]. Id.

[FN218]. Id.

[FN219]. Id. The office of the circuit solicitor made it clear that he was willing to prosecute when necessary. Id.

[FN220]. Id.

[FN221]. Id. Crack cocaine use is a felony in South Carolina. Id. The program was asking pregnant mothers to enter the program in good faith to stop abusing their unborn children with illegal drugs. Id.

[FN222]. Id. The hospital's goal in the crack-cocaine prevention program was to pro duce a healthy child. Id.

[FN223]. Id. Only two women continued to refuse treatment. Id. They were ultimately placed on probation. Id.

[FN224]. Id. Without any evidence, the Secretary of Health and Human Services, Donna Shalala, claimed that the program had "a chilling effect on minority pregnant women seeking prenatal health care." Id. Despite the fact that most of the women treated were black, the Police Chief, who was also African American, stated that this policy was not discriminatory. Id. He stated that cocaine use is more com mon in South Carolina among blacks than whites, and that he was glad to see that somebody was finally doing something to help the children in the black community. Id. Additionally, a federal judge refused to issue an injunction against the hospital to suspend the drug testing program because he found no basis for the discrimination charges. Id. See also Curridan, supra note 210, at D1. Placing criminal sanctions on a pregnant woman for drug use during pregnancy is punitive and turns pregnancy into a crime. Id. Prosecution of these women will "scare away the women most in need" of prenatal care. Id.

[FN225]. Condon, supra note 206, at 12. The Clinton administration stated that it would withhold millions of dollars from the Medical University, stop all Medicaid assistance, shut down its children's hospital and cancer center, discontinue numerous medical services, close down its 558 beds and ultimately force the hospital to turn away its patients, merely to stop a program that offended the liberal sensibilities of President Bill Clinton. Id. Ultimately, the President's administration held a gun to the hospital's head and forced them to give up a program they believed in. Id. The hospital had no choice; it had to protect all of its other patients. Id.

[FN226]. Id. Most drug and law enforcement officials agree that cocaine addicts need a strong motive to mend their destructive ways. Id.

[FN227]. Id. The program helped women invariably avoid going to jail. Id.

[FN228]. Bronstein, supra note 210, at E1.

[FN229]. Condon, supra note 206, at 12.

[FN230]. See John E.B. Myers, A Limited Role for the Legal System in Responding to Maternal Abuse During Pregnancy, 5 Notre Dame J.L. Ethics & Pub. Pol'y 747, 754-55 (1991).

[FN231]. Id. at 751-52.

[FN232]. Murtaugh & Capra, supra note 9, at 353.

[FN233]. See France Griggs, Mission Is to Find Safe Homes, Cin. Post, Dec. 26, 1994, at 6A.

[FN234]. Horowitcz, supra note 204, at 8.

[FN235]. Id. The written case plan must not, in any way, be deficient because efforts to later terminate parental rights may be defeated. Id.

[FN236]. Mayes et al., supra note 205, at 408.

[FN237]. Horowitcz, supra note 204, at 8.

[FN238]. Mayes et al., supra note 205, at 406. See also Treaster, supra note 63, at A1. Mothers should be taught how to calm irritable cocaine babies and how to get the babies to suck for proper feeding. Id.

[FN239]. Horowitcz, supra note 204, at 8.

[FN240]. Mayes et al., supra note 205, at 408.

[FN241]. Id.

[FN242]. Id.

[FN243]. Id. The National Commission on Infant Mortality suggested that "one stop shopping" may be the most effective system. Id. See e.g., Treaster, supra note 63, at A1. The most intense counseling and assistance program provided by a state would approximately cost $16,000 a year, as compared to $15,000 - $20,000 for foster home care. Id.

[FN244]. See, e.g., Kne, supra note 37, at 253. Successful intervention can only occur with cooperation from the home front. Id.

[FN245]. Id. If parents play an active role in the intervention plan and are kept well informed of their child's progress they are more likely to support the treatment plan and see more positive attributes in their children. Id.

[FN246]. Horowitcz, supra note 204, at 8.

[FN247]. Id.

[FN248]. Id. Some states, acknowledging that instability has detrimental effects on infants, have required periods of less than three months to prove that a parent's rights should be terminated. Id.

[FN249]. Id. By avoiding foster care, the costs absorbed by the state significantly de crease. See Phoebe Wall Howard, Lawsuit Against State to Help Foster Children Threatened. The Department of Human Services is Supposed to Find Adoptive Par ents for Some Foster Children, Des Moines Reg., Sept. 21, 1994, at 4. The average yearly cost to the state of maintaining a child in adoptive placement is ap proximately $3900. Id. The average cost for maintaining a child in foster care is roughly $10,000 - $40,400. Id.

[FN250]. See DeBettencourt, supra note 10, at 17. The child would consequently be placed with an adoption agency. Id. When reunification is impossible for a baby and a mother addicted to drugs, adoption is in the best interest of the child. Id. See also Craig, supra note 65, at 41. For every child that is ready and able for a permanent home, there are scores of families waiting to adopt a child. Id. The idea that adoptive parents only want "healthy, white babies" is a myth. Id. There are waiting lists for parents willing to adopt white children, black children, Hispanic children, Down's Syndrome children and AIDS children. Id.

[FN251]. DeBettencourt, supra note 10, at 17. When the state removes a child from a mother addicted to cocaine, the state's first preference is reunification with the bio logical parents. Id. See also Toufexis, supra note 10, at 56. In one study, 300 cocaine-exposed infants and their mothers immediately received intensive postnatal intervention. Id. "Of (the) 90 children tested at age three, 90% showed normal intelligence, 70% had no behavioral problems, and 60% did not need speech therapy." Id.

[FN252]. See, e.g., Andrea Neal, Agreement Puts Foster Children First: Board Sets Goals to Speed Placement of Youngsters Stuck in Welfare System, Indianapolis Star, Jan. 6, 1994, at E1.

[FN253]. Treaster, supra note 63. The children are spared the cold, impersonal and unstable experience of life in a foster home. Id. Since the state would be making efforts to end the mother's drug use and to strengthen the family, the child is given the chance to live in his own home with his ownbiological parents. Id.

[FN254]. Id. This type of program can break the cycle of a mother giving birth to a cocaine baby, placing the child in foster care, going back to the streets and giving birth to another cocaine baby. Id.

[FN255]. Lacayo, supra note 14, at 22.

[FN256]. Jill Severn, Government Alone Unable to Save America's Children, Seattle Post-Intelligencer, Nov. 11, 1994, at A15.

[FN257]. Id.

[FN258]. Severn, supra note 256, at A15.

[FN259]. In re Doe, 627 N.E.2d 648, 653 (Ill. App. Ct. 1993).

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